

HIT Policy: Quality Measures Workgroup

Draft Transcript

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Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody and welcome to the Quality Measures Workgroup. This is operating under the auspices of the Federal Advisory Committee Act, which means there will be an opportunity at the end of the meeting for the public to make comments. Let me just remind workgroup members to please identify yourselves when speaking for attribution.

We have a number of members here in the room, as well as on the phone, so let me go around and ask you to introduce yourselves, beginning with Dr. Reider.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

Good morning, I'm Jacob Reider, Chief Medical Informatics Officer from Allscripts and member of the executive committee of the Electronic Health Records Association.

Peter Basch – MedStar Health – Medical Director

Good morning. I'm Dr. Peter Basch. I am a practicing internist and medical director for our EHR implementation at MedStar Health.

Christine Bechtel – National Partnership for Women & Families – VP

Christine Bechtel, National Partnership for Women & Families.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Jim Walker. I'm the chief health information officer at Geisinger Health Systems.

Tripp Bradd – Skyline Family Practice – Physician

I'm Tripp Bradd, a family physician just 70 miles west of here.

Helen Burstin – NQF – Senior VP, Performance Measures

Good morning. Helen Burstin, Senior Vice President for Performance Measures of the National Quality Forum.

Ahmed Calvo – HRSA – Senior Medical Officer

Good morning. Ahmed Calvo, Senior Medical Officer at HRSA.

Sarah Scholle – NCQA – Assistant Vice President, Research

Sarah Hudson Scholle, Vice President for Research at NCQA.

Judy Sparrow – Office of the National Coordinator – Executive Director

On the phone we have David Lansky. David, are you there? All right. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marc Overhage?

Marc Overhage – Regenstrief – Director

Marc Overhage. I'm with the Regenstrief Institute and the Indiana Health Information Exchange.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jesse Singer? Russ Branzell? Wesley Clark? Gene Nelson?

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

Good morning from Dartmouth Medical School.

Judy Sparrow – Office of the National Coordinator – Executive Director

Neil Calman? Norma Lang?

Norma Lang – University of Wisconsin and American Nurses Association

Good morning, University of Wisconsin and the American Nurses Association.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tim Ferris? Cary Sennett?

Cary Sennett – MedAssurant – Chief Medical Officer

Good morning. ... Chief Medical Officer at MedAssurant.

Judy Sparrow – Office of the National Coordinator – Executive Director

Let me ask again, is David Lansky on the phone, please? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

David, I know is on the phone because I'm getting e-mail traffic from him. But that's okay, I'll go ahead and welcome everybody. I'm Christine Bechtel, as I said. I will be filling in for David Lansky and for Dr. Blumenthal, who co-chairs our Quality Measures Workgroup. So first let me—

David Kendrick – Greater Tulsa Health Access Network – Principle Investigator

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Christine Bechtel – National Partnership for Women & Families – VP

Oh, there he is. David?

David Kendrick – Greater Tulsa Health Access Network – Principle Investigator

This is actually David Kendrick from the Greater Tulsa Health Access Network and University of Oklahoma.

Christine Bechtel – National Partnership for Women & Families – VP

Terrific. Are there any other workgroup members on the phone that want to introduce themselves?

Paul Wallace – Kaiser Permanente – Medical Director

Good morning. This is Paul Wallace from Kaiser Permanente.

Christine Bechtel – National Partnership for Women & Families – VP

Hi, Paul. So let us jump right in. First, let me say thank you to everybody for putting up with an interesting hotel location. Apparently, Jon Stewart and Stephen Colbert are taking up the entire Mall along with the Marine Corps marathon, so here we are.

The purpose of our work today is to really put some final touches on the work that the Tiger Teams have done to create a set of measure concepts and identify gaps in measurement that might need to be filled, and I should say that's in the context of stages two and three of meaningful use. As you all know, ONC and the HIT policy committee are going to issue a request for information probably in early November to

understand from the public what measures are out there and how we might go about filling gaps, on what timelines, etc., and so that we can really drive some innovation in the context of quality measures that leverage electronic clinical information from electronic health records, of course.

I think that it's important to understand that this work is not proceeding in isolation. There is a federal coordinating committee that is also being informed by this work that includes representatives from multiple federal health agencies who are engaged in quality measurement and improvement. So while our media context is meaningful use, this process certainly has an enormous amount of potential to inform the work of the federal government in a lot of different health programs. ONC will then issue a request for proposal, probably in December, so that we can begin to fund some of the measure development, gap analysis, and filling those gaps so that we may be able to then consider what measures would be appropriate for stages two and three of meaningful use.

Let me first say that this has been a terrific effort on behalf of many people, including of course Dr. Blumenthal and David Lansky and all of the workgroup members and the experts who have been serving on Tiger Teams that have been meeting on a very tight timeline and producing a terrific amount of thought leadership, which we'll hear about today. But I also want to recognize the ONC staff, who have really carried an enormous load in supporting this process and providing us with the guidance that we need.

So I'll give you the list of folks that I know of that have been involved with great things, and that's Lanre Akintujoye, Leah Marcotte, Allen Traylor, Josh Seidman, Judy Sparrow, of course, Jon White from AHRQ, Tom Sang, Craig Milford, and of course our own Farzad Mostashari. Thank you all very much. I want to actually invite you guys from ONC to come up to the table, you've got some name tags and we will probably be calling on you. Anyway, so thank you very much.

We're going to do two things today. We're going to start the day with a panel of experts who we've asked to share their views on the quality measurement process and gap identification. Then we're going to hear from the chairs or co-chairs of each individual Tiger Team about the measure concepts that they have identified for potential inclusion in the RFI/RFP, and I'll talk more about some guidelines for that discussion when we arrive at it. But first we'll start with a terrific panel. We've asked the panelists to talk about the importance of clinical quality measures to the communities that they work with or represent, including how their organization is using quality measures, if that's applicable to them, as well as sharing their views on the existing measurement process and how it might need to evolve in order to best leverage electronic clinical data from electronic health records. We've also asked them to identify opportunities and barriers to really advance the state and the science of quality measurements.

So first we're going to hear from Joyce DuBow from AARP, and she is the Senior Adviser for AARP's Office of Policy and Strategy, where she has a very broad health care portfolio. I've known Joyce for many years and she's terrific to work with. She serves on a number of committees and task forces related to quality improvement and measurement, including NQF, JCAHO, NCQA, and pretty much the entire alphabet soup list.

Then we're going to hear from Fred Rachman. Am I saying your last name right?

Fred Rachman – Alliance of Chicago Community Health Services - CEO

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Great. I thought B-E-C-H, Bechtel, I was hoping. Anyway, so Dr. Rachman is the CEO of the Alliance of Chicago Community Health Services, which is a HRSA funded network of primary care community health centers that supports a centrally hosted EHR system that is shared by 24 Safety Net health centers in 8 different states. He's also a pediatrician in active practice.

Paul Wallace, who you heard before his voice, he's on the phone with us today, he is the medical director with the Permanente federation. He's the medical director for Health and Productivity Management programs and the senior adviser for the Care Management Institute at Aviva Health, which is a Kaiser Permanente disease management company that they established in 2005.

Then finally we'll hear from Joachim Roski with the Brookings Institution. He is the Research Director for the Engelberg Center for Health Care Reform, where he does an enormous amount of work on a broad range of topics, ACOs, etc., etc., but has a huge focus on the activities of the Quality Alliance steering committee.

Welcome to all of you. Thank you so much for your time today. You all have written testimony in your packet from each of these panelists, and we'll get started with Joyce.

Joyce DuBow – AARP Public Policy Institute – Associate Director

Good morning, everybody. I am Joyce DuBow from AARP, and for those of you who don't know AARP is a consumer organization. We have millions of members across the country and in all of the states. We have an office in every state and the territories and we have a broad range of interests in health care. In particular, we were very ardent advocates for health care reform for a long time, we supported the quality provisions in the ... and HITECH, so we have a very keen interest in these issues.

My job is to represent the consumer perspective this morning, and so I'm going to focus on those consumer focused measures that we have a particular interest in seeing adapted into stage two and stage three. I am going to answer the questions that were posed. I thought Judy would be having a stop watch and I would be monitored very quickly and carefully, so I'm going to speak fast but I'm going to try to direct myself to the questions that were posed.

The first question was why our community of consumers has an interest in clinical quality measures. Of course that's an obvious one to us. We see the deficits in quality, the problems, the uneven patterns of care, we see rising health care costs, we see a lack of a patient-centric system, and we think that measurement will help spur improvement. So we are very, very interested in making sure that there are the right measures to stimulate the direction that we think the system should go in. We think that measurement should be comprehensive, and I do take issue with the question that focused on clinical quality measures because we think that patient-centered measures may not fall into that category, like patient experience measures, for example.

So we would like to emphasize the importance of having a comprehensive approach to measurement that addresses the six These measures should fit into that framework so that we can hit every one. Patient-centered of course is one of the six domains, but so is efficiency, we're concerned about resource use, its effectiveness, patient safety, equity, timeliness, etc. As I say, we think that the measure and activities need to go beyond clinical quality. We need to capture patient experience, patient activation, shared decision making, the quality of decisions that are made. That includes broadly knowledge of the things that have to be considered in order to make a decision as well as whether an individual's preferences, personal circumstances and values are represented.

Patient reported outcomes like functional status, social, emotional, cognitive, pain status, quality of life, we think these kinds of measures need to be included and therefore we think that the technology has to be prepared to collect data that will enable us to have measures to do that. These are most salient to patients. I think that is probably very obvious, but should be emphasized, measures that can assess performance, of course the continuum of care is also very important. We think that we need episodes to be measured. That's how patients experience care, so that by definition it becomes a patient focused approach to measurement if we look across the continuum of care and across the episode that a patient experiences.

We think that results should be stratified by race, age, ethnicity, primary language, as well as sexual orientation and gender identity. We're becoming more aware at AARP, we have developing policies about this particular group of patients whose data are not known. We don't know how many people in the LGBT community are out there. We need to throw that demographic into the mix with respect to data collection.

I also had mentioned that when we think about the unit of analysis patients are going to want the information about their own clinicians, that's physicians, that's nurse practitioners, physician assistants, patients want granular information. Obviously we know it's not feasible all the time, but that's really the unit of analysis that most patients are interested in and we would like to see that happen.

The next question is how AARP is using clinical quality measures and patient reported data. AARP provides information to our members and to the public at large and we also advocate, we have been supporting public reporting for a long time. That's a big part of our state based quality agenda, where when these things come up in state legislatures we are in the forefront in terms of advocacy for public reporting. Obviously, in order to have good, useful public reports you need to have valid, reliable measures. Our preference is to have measures that are NQF endorsed. We want to see measures that are standardized. We want to be able to make apples-to-apples comparisons. We don't think it's a good use of resources to see mom-and-pop kinds of measures. We would like to have standardized measures. So AARP advocates for that. That's one way we use measures, is to promote public reporting.

We also, as I say, provide a lot of information. We link to public reports. We write articles. We have a big communication network. We have a magazine that reaches 35 million people a month, *AARP Magazine*. We have the bulletin, which is a monthly newspaper kind of publication that also reaches close to 30 million people. We have stories in there about health care acquired infections. It used to feature a monthly article by Carolyn Clancy on the importance of using evidence and other things that are of importance to consumers. These all are tangentially related to measurement, but they are absolutely related to what people can do to improve the quality of their care.

We will continue to use measures in that way, both as an information tool as well as for advocacy of it, because as I say, we feel very, very strongly about accountability through transparency, which means we need to rely on good, sound measures. I also expect that given the new payment methodology for Medicare Advantage and the star system that will be used and integrated into the payment system that we will be producing more stories on what this system means to consumers, and of course that system relies on the use of measures.

So how should the traditional measure process evolve to capture robust clinical data? We know that the current measure process focuses on discrete condition specific measures not usually HIT enabled, great reliance on claims data that are un-enriched with pharmacy or lab data, and we understand why. This is an evolutionary process. I don't say that critically. I just say that as that's where we are now. I think that we are making rapid progress. It leads with the recognition of the stakeholders at the table that we need to move forward to have a more robust comprehensive set of measures. I hope I'm not being overly optimistic in saying that I think that there's a greater appreciation for the need to have more patient focused measurement, an acknowledgment that patient experience is a very, very important piece of information to motivate improvement. It does have an impact on health outcomes and we think it's critically important.

Patient-centered outcome measures are very important. We ought to be measuring the outcome from the patient's perspective. That's what it's all about. I hope I'm not wrong when I say I think that there is greater recognition of the importance of these measures. But that's what we think is really, really important. Of course, stage one set a very, very reasonable set of requirements. I think it's fair to say that consumers and purchasers, if I can speak for them too, are eager to see, now that we've set the

parameters for the going in stage to be more aggressive in really seeing a sharpening of these tools to focus on the kind of patient focused measures that we think we need.

Everybody now knows, the signals have been sent, they can have an opportunity to gain some experience in stage one. We're really ready to roll up our sleeves and to – I know we asked for it in stage one, but we think that the way stage one came out was reasonable enough, but I think that our standards are going to be set higher for stage two, our expectations certainly, to see stage two and stage three really get in there and look at a stronger, more focused set of measures that speak to these issues that I've been describing. We hope that the funding that comes with the ACA and the monies that ONC has for measures will be devoted to the development of these kinds of measures.

We think that the national strategy that the secretary is going to announce shortly is a great opportunity to align everybody's efforts and expectations. In our letter, in AARP's letter, we urge the secretary to pay a lot of attention in the better care piece of the triple aim to focus on patient engagement and ways to help activate, to get people more engaged in their care. We don't think patient engagement is the only way to improve care, but we sure think it's necessary. It's necessary, but not sufficient. It's not only consumers who are going to fix things, but they have an important role and we need to provide tools and we need to harness the technology in order to help them do that.

So opportunities to advance measurement are, as I say, stage two and stage three, again, using the technology to harness and to engage patients. The transactional opportunities and advantages that come with the electronic records are very obvious to the people who use them. I don't think we're going to have a big sales job convincing people that it's really nifty to be able to e-mail your clinicians and to get a response, to be able to tap into your test results quickly. This is an engaging process. When you pay attention to your results, you are engaged in your care. You see lab results that are out of whack you need to know, and you're probably inclined to ask, "What do I do about it?" if the advice is not forthcoming. So we think that there are many opportunities to use the technology. It should facilitate delivery as well and as I say, the technology should enhance the care experience for patients.

We also think that there are opportunities with the technology to tie people to their communities. AARP represents people who are 50 and over, and in particular those people who are retired and living in the communities, there are many opportunities to use technologies to take advantage of community resources, to prolong independence, to enable people to continue living independently in their homes, technology can advance that, and we are very, very interested in seeing how the technology can do it.

Barriers to developing electronic clinical measures, I guess I would say, before I talk about the barriers, that we know that there's going to be a transition period. We're not going to wake up tomorrow and see everything HIT enabled. It's going to take a while. I know that NQF and others are engaged in a retooling effort of the existing measures, but we're going to need additional measures, Christine talked about the gap, and everybody knows that. But they're not going to be available overnight. And we are going to have a period when we are going to be using data sources that are less than ideal and we're going to have to tolerate that because I think that it's fair to say that patients, consumers and purchasers by not going to sit on the sidelines while these new measures are being developed, the need for information is not going to go away while the development process happens.

So we are going to have to tolerate less than ideal measures. The clinically enriched measures that have been recently endorsed at NQF are an opportunity to make things a little bit better. I personally don't think we should invest tons of money in that because that's not where the future lies, I don't think, but I think we need to recognize that we have to make do as best we can with the current measures as we transition to something more robust.

I think resistance from the provider community is likely and real and we need to deal with it. Risk adjustment for electronically specified measures is going to be the same as we have now. We need to be sure that measures are fair, that they are reliable, AARP has subscribed to the patient charter that defines

a process that tries to ensure that the measure methodologies are fair. We think they should be, but we also have to come to consensus around what's good enough, because we're never going to have perfect measures and we know that. So we need to bridge these barriers.

I think that, as I said before, agreement on priorities is very, very important so that we don't have a scatter shot approach to measurement. We as consumers want to see heavy investment in the development of consumer focused measurement so that we have the information we need. There are other priorities, obviously, but we think this one is really first among

The other concern of course is that in the transition period we're going to have apples and pears and we're going to have to make it clear to people how they use these measures and how they compare one to the other. I think that's a communication issue that we're going to have to come to grips with.

Finally, I would just like to say that in terms of the e-measures that we expect to see, I have heard information from people who work with electronic records that it's very costly to update these measures when new evidence comes about. I think that's a really serious concern. I don't, frankly, know too much about it. But I worry about that a lot, that it's costly. I've heard people who have used EPIC, for example, who say it's very, very expensive to update the measures with new specifications. I just would like to flag that as a concern, because we want these measures to be good, strong, robust measures and we want to be sure that they reflect current evidence.

So with that, I thank you and I'm happy to answer any questions you have.

Christine Bechtel – National Partnership for Women & Families – VP

What we'll do is go ahead with the rest of the panelists, but as you are thinking and formulating your questions jot them down, because we'll definitely have some time for robust discussion with the entire panel at the end. Dr. Rachman?

Fred Rachman – Alliance of Chicago Community Health Services - CEO

Thank you for asking me to share our perspective from the community health center world. It's thrilling to follow Joyce, because it's great to build off of the patient perspective, and I'll be underscoring many of the points that you made.

I would like to talk from some slides, because it will keep me from rambling in my enthusiasm for the topic. I just did want to start with a tiny bit of level setting about the community health center. I know, recognizing a lot of the names in the panel, many of you know, but it's still surprising to me how little known community health centers are. Community health centers date back to the '60s and form a very, very significant and organized sector of the Safety Net and have a comprehensive model of primary care covering not only the medical aspects of care, but wraparound services, not only dental, behavioral health and nutrition, but things like case management, social services, and health education, so a very robust model of care. Today there are more than 1,100 health centers in the country and that number features very prominently in health reform, with targeted expansion. Even today more than 1 in 20 people, more than 5% of the population receives care in one of these centers, so it's definitely a significant part of the Safety Net.

I will get to the questions. Don't worry. In this discussion it's very significant that health centers bring an experience of reporting on quality measures that goes back quite some time, this coming not only from requirements for the funding, where their funding source is both federal and local and often private, require reporting on quality measures, but also from an experience in chronic disease management using evidence based practice guidelines and using measures building off of those. So there is a very rich experience in these centers with the concept of using quality measures. There has been an investment over the last decade by HRSA in a very organized way in health information technology and that I think follows naturally from this interest that health centers have in use of data and quality measures.

The organization I work for represents first recognition that quality measurement and health information technology require a very, very deep set of technology resources and expertise, and have encouraged the centers to work together by creating the kind of health center controlled network, which is what the alliance is. And as you heard in the introduction, we have focused very heavily on health information technology and today support a system that is shared by 28 health centers operating out of about 100 sites in 10 states.

This is an example of performance measurement layered into an electronic health record. This is a screen shot from the system we're using for diabetes, and it shows how a practice guideline can then be used to compare in real-time at point of care the patient status with regard to that measure and give a practitioner an opportunity to address it at that point, and prompt. So as I make my remarks, I think it's significant that our view of quality measurement is that it's carried all the way through to the actual point of care and the patient interaction. I think more of the focus is on what we do at population level.

So just an example, again, from our use of quality measures is a dashboard format, it's an eye chart. It does not matter because it's meant to draw attention to stakeholders to particular trends in data so that the noise of all the rich data that we have from the promulgation of quality measures doesn't get drowned out and that we're able to focus on what's important, which is addressing efforts, just some more snapshots of data, the ability to be able to now compare practice level data to national level data and look at disparities.

So again just to finish up this little intro, our health centers are already reporting quality measures from multiple sources, including a uniform clinical data set and administrative data set for our major funder. We report these measures of these management programs, HIV measures that are carried through the Ryan White program and then a variety of more local measures that the centers all report.

So the questions, why are measures important? First of all, we are required to report quality measures as health centers, but what we've learned from that is that it's been very significant in providing recognition for the services that we provide. And I think that it's not a coincidence that health centers have then been identified for expansion, because we're able to demonstrate both the quality and the breadth of the services that we provide.

They definitely have been used to guide our practice performance improvement efforts and system level change. There are some examples in the testimony from some of our centers of how we've been using them, and I'll get to those in just a bit. They also have been an opportunity, by having standardized measures that overarch all of the health centers nationally it is a starting point for centers to be able to look and compare their experience, identify not only the disparities, but identifying where there are strengths in performance and allowing us to benchmark and share best practices.

How has measurement evolved? That was part of this question, and so our experience is that these measures began in the manual. I have enough gray hair to remember that originally we recorded these measures by laborious chart audits and those were based on only samples of populations. Then as automated practice management systems came in, we were able to do some of the reporting out of wherever there was claims based or practice management related data, we could pull data from there. Health centers became very, very creative in creating dummy payer codes or false kinds of service codes in order to leverage that system to report some of these quality measures. That has had some detrimental effects, as we've moved forward, because we've had some very, very quirky use of these practice management systems in health centers that need to be overcome as we come to more modern integrated clinical systems.

That evolved as we had experience with chronic disease management, to use of chronic disease management systems. These systems certainly gave us more clinical use and ability to track measures and use them in care. They are limited by the fact that there's labor intensive data entry that's often separate from the care process. Again, it's not always possible to put the universe of patients into these

systems, and that separation from the actual care process limits its ability to inform the patient interaction. So that brings us to EMR, where I think everybody is clear about where we are with trying to layer the measures into EMR.

So how we're using them today in our health centers, so you saw some clues from the slides I showed you. First of all, we incorporate them into decision support at the patient level, so we have endeavored to build screens within the EMR so that those measures are presented to the practitioner as a prompt at the point where they're able to do something while the patient is in the room.

The second is using it for performance and outcomes benchmarking. That dashboard that you saw is one that we publish. We have clinician meetings where they're viewed by clinicians, so there's an opportunity for discussion amongst the various practices about trends. It's also presented to our leadership group, our board, so it becomes a real opportunity for us to compare experience.

They're being used by the centers within their individual performance improvement programs. It's great that they're layered in so that there becomes some objective measure tied to patient outcomes in quality that's driving where the focus is. In some cases our centers are using them for provider incentive and feedback. For example, I am subject to this myself, where on an annual basis I sit with my clinical supervisor from a portion of my life as a practitioner and my performance on the measures is reviewed and goals are set.

It is definitely used to guide program and services development. So, for example, at one of our centers noting the poor performance on eye screening it prompted that organization to spend resources to bring ophthalmology and screening services into the health center that would not have occurred without that objective feedback. It's also used to develop targeted intervention, so we've begun to trigger, if there's poor performance or a deferment of a practice recommendation, have that be an automatic trigger for interventions. One of our centers is now compiling data showing that by linking a patient refusal or reluctance to get colon screening to a community based intervention we've increased the screening outcome by six-fold. So very, very rich ways that these measures can impact practice at every level.

I'm going to pick up on some of Joyce's themes, thinking of future evolution we also believe, especially from the rich model of services that we have in community health centers, that the scope of services needs to evolve beyond medical services. I'm very humble in my work in an exam room that what I do in that patient visit has a very, very small ultimate impact on what happens with that patient, and it's all the other services, it's the reason I work in a community health center, is that we focus on all of those other things that are important in improving outcomes. So I think it's important for us to reflect that in the quality measurement system. I also want to echo what Joyce said, I'm going to reiterate that point in a bit, about making sure that we're covering dimensions of quality. We also use the Institute of Medicine dimensions, so I also would echo that.

We think it's very important to focus on reasons for non-adherence to the measures. There's as much to learn from non-adherence as there is from adherence, and the point of this should not be to give someone a grade and score them. The point of this should be to lead the path to improving outcomes in quality. So by encouraging people to document non-adherence and to make sure that we're learning as much from that as we are from good performance I think we're going to lead ourselves in a better direction and we're also going to bring people to the table in a different spirit.

Finally, closer alignment to practice recommendations, and this is going to be very challenging but one of the things now is we're very mindful, it's been very, very hard to drive consensus on performance and quality measures, and we do that by having them be less stringent than the practice recommendation itself. I think we also do that because of the sphere of the grade. However, if we're going to use the quality measure to actually prompt and use it for clinical decision support, the closer it is to the rigor of the practice recommendation, the more useful it's going to be.

What are some opportunities, looking forward? Again, balancing these measures across the dimensions of quality, I love that we heard that also from the patient perspective. I think that's absolutely right. I think currently we're focusing much more closely on actual medical measures and some very specific aspects of recommendations, so looking at some of the other very important things, marrying clinic measures to financial measures, which we're able to collect from integrated systems, will allow us to look at things like efficiency, not only efficiency of uses of resources by us as health practices, which I think we focus on a lot, but efficient use of our patient resources, patient-centeredness, I just echo everything that Joyce so eloquently articulated, expansion, as I said, to other aspects, nursing, nutrition, behavioral health, social services, health education, again, patient level measures.

Layering measures aligned to levels of this system, so right now I perceive that a lot of the conversations with individual providers and practices and fear about quality measures is where we're assigning the responsibility, and I think it's absolutely right to be measuring these at practice and provider and patient level. But ultimately many of these are measures of how we're performing as a system, they're measures of public health performance, they're measures of even payer system performance, so there can be a more deliberate attempt to layer these measures and align them in these places so that it's more clear who we're holding responsible, and again to be bringing people to the table in a very different spirit.

Structural measures, I think we're really beginning this with the measures from meaningful use, which are looking not only at the actual clinical or outcome measures, but are looking at some use, some things that we're doing in the system, the way we're using electronic health records that are likely to impact care in a positive way. I think this goes way beyond technology. I think Joyce touched on this as well, but other aspects of the system that lead to quality health care, some measures of those that relate then ultimately to quality.

Finally, integration of measures, so in the community health center world we have a great perspective of many other sorts of federal, state funded initiatives that relate to health care, things like housing, substance abuse, and there's an opportunity to combine or layer or integrate those measures with our more health care focused measures for a more robust view of things.

I change the word "challenges" in my mind to "considerations" because in my toil I hate to think of these as barriers or challenges. I think of them as considerations in our work going forward. But I'm going to start with this little graphic here, it's a bit of an eye chart for a room this big, but what it's really meant to reflect is that we should be very, very humble in where we are in the art and science of actually collecting measures electronically and that there's a hierarchy of how these measures get into the system, from very simple ones, so if I order a lab test in the system and that's a measure, there's no degree of separation between my clinical act and that measure.

But as we go up, each successive complexity in the measure is introducing more confounding variables to what we're seeing in that measure, so this slide going up even just a blood pressure or a weight is now reliant on that clinical staff person, if it's not an integrated medical device, is reliant on that staff person correctly putting the numbers in, putting it into the space, remembering to transfer it from their hands into the electronic record, going up to where there is a requirement for a practitioner in delivering care to adhere to a data capture design and putting it in the right place, all the way through to where we have information that's coming from outside of the system, outside of the practice, screening mammogram results, things like this, where there may not even be a formal relationship for that data to come back in. So a lot of humility here in the tranches of data.

Just echoing the need for measure alignment for multiple reasons, the importance of defining disparity populations and identifying them consistently, we were fortunate to do some work with the Health Research Education Trust on looking at how disparity data is collected, and I really echo everything Joyce said there, but there is a competency to collecting that data accurately and unless we pay attention to that we're going to have to interpret our results with great caution. Being thoughtful, again, as I said about the level of accountability, the magnitude of change is the way I would interpret much of what Joyce talked

about with resistance, and we have to recognize that there's an enormous and accelerating pace of change in health care and somehow we have to recognize that and we have to assist all levels of the health system with dealing with that.

Finally, I'm very thoughtful that if we're measuring something we should be measuring things that we are thoughtful about some ability to respond to. And here I think is where I think we should put our most thought, and that we're again layering these measures to places where we're really believing that there's some ability to impact, we're really going to moralize everyone if we report we get to level three and we're holding practitioners accountable for results and we know that all of the complexities that go into our health system and health status as a nation are mitigating what they were able to do really in an exam room.

So I want to end with this little graphic for you that technology is happening at a variety of levels, it's happening at the EMR level for us as individual practitioners, it's happening through health information exchange at the system level, and it's also, thankfully happening at the patient level through the emergence of personal health records. We ought to be thinking as we're thinking about performance measurements, how we measure, how we recognize all of these areas in which we're collecting data and how we're then marrying those measures to not just accountability but actionability things.

I apologize. I'm going to need to leave to another speaking engagement, so I might miss the questions.

Christine Bechtel – National Partnership for Women & Families – VP

Thank you, Dr. Rachman. We probably know how to find you should we have questions. With apologies, I've been doing a terrible job managing time, so Paul and Joachim, my apologies for that. Paul, let's go to you, and you're on the phone.

Paul Wallace – Kaiser Permanente – Medical Director

Good morning. I'm Paul Wallace and I'm a medical director with Kaiser Permanente. I and my colleagues from KP wanted to thank you for the opportunity to share our experience. I was asked to comment on our perspective as a payer. I know there are several other folks on the phone who come from integrated systems with varieties of degrees of integration and will recognize the challenge of trying to separate the payer from the other components in an integrated system, and I think my comments will largely be at a system level with at least some comments about how particularly this plays out for a payer.

I'll give a few background comments about Kaiser Permanente just as context and then proceed to address the question. So as many of you know, KP is the largest not-for-profit integrated health care delivery system in the United States. We serve 8.6 million members in 8 different regions. The KP medical care program really includes three different organizations: the Kaiser Foundation Health Plan, which provides the insurance coverage; the Kaiser Foundation Hospitals, which owns and operates the hospitals; and our medical groups, which are regionally defined. The medical group provides service for Kaiser health plan members exclusively and the health plan exclusively contracts with the medical groups. In 2010 we completed implementation of our electronic health record, which we have branded KP Health Connect, and it's largely from EPIC systems, it's a comprehensive electronic health record system that securely connects all members' medical records across both the ambulatory and inpatient setting, integrates billing, scheduling, registration, and provides members access to a personal health record on our organization's Web-based portal, KP.org.

I guess you could frame this in a different way to say that we have successfully disrupted the practice and work lives of 15,000 physicians, 40,000 nurses, and 100,000 other staff and came out the other end and lived to talk about it. A lot of the work of integrating quality measurement remains very much a work in progress. We also recognize that part of the challenge here is to productively disrupt the relationship of patients with the health care system, particularly placing patients at the middle, which has not been their traditional place.

As a fully integrated health care system serving payer and provider interests within a single system aligned for quality and cost, KP is an exception in the U.S. health care industry. Because of its relatively unique approach to care delivery, accountability, and payment, as well as the comprehensive EHR, KP's perspective and experience can ideally aid in thinking about meaningful use to promote adoption of health information technology. In our model the medical groups have incentives to accept full accountability to the health plan for the cost and quality of care, and this relationship mirrors the payer/provider relationship assumed in the context of meaningful use of EHRs.

The development of sustainability of the relationship between KP's various parts, particularly the payer and provider relationship, has always depended upon a common mission and an organizational strategy focused primarily on quality and efficiency. So as much as quality improvement at KP is dependent on implementation of the EHR in recent years, the ability to harvest value from the EHR has relied on reengineering the organization's quality and service agenda to leverage the benefits of EHR. The two are inseparable and I think an important linkage to the other work going on within HHS to think about an evolving quality strategy.

A key aspect of the process for us within Kaiser Permanente has been a multi-year, total system quality assessment launched by the program's quality committee to strengthen system-wide quality performance goals, build a robust quality infrastructure, create clear lines of accountability at all levels of the organization, and make really a fundamental shift within the organization from thinking about accountability in terms of historically we believe we deliver the highest care through our current framing based on transparency of the numbers tells the story.

So to specifically address the questions that were posed, first, prior clinical quality measures important to you and your community. As I mentioned before, quality improvement is the core organizational strategy and measurement drives and supports this. It's the foundation for fulfillment of our key strategic need to maximize the flow of timely, accurate and relevant information to decision makers and action initiators. More specifically, measures help us in three fundamental ways. They reflect the value of services delivered, both through our internal organizational governance and deeply important to our customers, on a macro level to employers, but also to the consumer as a customer. They support the identification of priorities and serve to align critical constituencies, including having shared performance incentives across all aspects of the organization. Also, it's a communication tool that emphasizes priorities to the organization, plus progress towards both targets.

We were asked to comment on the evolution of traditional claims based quality measures and to clinical quality measures based on EHR data, and one of the paradoxes for us is that historically we actually have had very little claims generation. We're a prepaid and fully capitated organization that historically has not generated medical claims, although more recently we have adapted to new insurance payment regulatory and network designs and can generate claims, although we generally see claims as a secondary source of data and prefer other "administrative" sources such as membership, finance systems, hospital management, scheduling, and the like. Much of our historical pre-EHR reporting used data not generated through claims. EHR data has expanded the capture of non-transactional events and information, plus it also has made the capture of transactional information more efficient and complete. In fact, in multiple dimensions, including clinical results, expanded demographics, including capture of race and ethnicity and other data reflecting patient need, circumstance and preference.

I think the second question was how is our organization using clinical quality measures and patient recorded data. We looked at the EHR enhancing our ability in three ways. One, efficiency of measurement, we can just measure more things. We can actually do the same things we've done in the past more efficiently. Second, is increasing bandwidth so we can measure more things. The third is innovation, where we can measure things we couldn't measure before.

In the written testimony there are some detailed explanations, which because of time I'm not going to go through in depth, but some quick allusions to those examples. In terms of hypertension control, our ability

to move from what had classically been the hunt and gather ... approach of chart review to being able to support frequent measurement of blood pressure at a local level allowed us across our plan to have fairly dramatic improvement in quality improvement and the critical factor in this improvement was the ability to measure and communicate the level of blood pressure control frequently, serially, and broken down by practice unit. So the ability to get quarterly results at the practice level fundamentally drives improvement in a different way.

A second example is our ability within the inpatient setting, we haven't really talked much about inpatient, but within the inpatient setting there's really an incredible wealth of opportunity that I think gives us the ability to expand bandwidth. We focused on trying to identify early patients at risk of sepsis and using decision support be sure that they get appropriate treatment. In thinking about population based care, there are opportunities to measure the things that we could never do before. A critical challenge for us in managing a practice is to focus on where are the greatest opportunities for serving a particular ... within a population.

One way to think about that is which set of patients have the largest number of gaps in care. Particularly for the patients with co-morbidities it's been extremely difficult to look at in classical disease oriented clinical measures, but with EHR we're able to look across the population and identify patients who across condition groups have increased numbers of gaps of care, we can communicate that information to our clinicians, and are seeing an increased rate of gap closure.

Finally, in terms of collecting patient generated data, we've honestly not focused a huge amount of resources on expanding our capabilities. We have done multiple pilots with health risk assessments, but particularly where we've been experimenting is how we can increase the connectivity between our system and with a patient through the personal health record. I think that we've had a great deal of success in engaging increasing numbers of our members and using many of the functionalities, including many of the things that were alluded to before about looking up lab results and using The challenge there is the data is often unstructured, but there is the opportunity to increasingly structure the data.

In our opinion what are the issues about the traditional measure process that need to evolve? Well, one of the biggest issues from a system level is the abundance of data produced by EHR. It's a challenge to store. It's a challenge to use productively. It also involves substantial cost. Further, not all data in the EHR is discrete and well defined. Certain information, like progress notes, can't be captured in structured data.

If we think about measures going forward, ideally the elements supporting an e-measure should be a natural artifact of the clinical workflow and represent a relatively standard aspect of documentation. But this becomes a huge challenge when you operate across a large health system with multiple workflows that need to be served by the data being generated. We've found that it's important to prioritize and design measures to address the critical questions of key decision makers and action initiators, and then source the data back to the EMR.

What are some opportunities to advance measure development? We would very much support the current process to design with the end in mind to systematically figure out what are the critical questions among decision makers, and then pursue and develop the data to be able to form the measure, to be able to support increased frequency of measurement trending over time and application of measures of population, so hypertension, the example that I talked about before, and to be able to expand the perspective when new measures are developed and sustained. I think that reinforces both being able to serve broader groups of patients, looking at race and ethnicity, but also looking at other groups of practice. We haven't talked much about nursing, but nursing specific measures such as pressure ulcer management and pressure ulcer prevention may be key opportunities within the inpatient setting.

Finally, then what are the barriers to developing electronic clinical quality measures? I've alluded to this before, but the vast majority of data that is collected tends to be non-discrete and well defined, where e-

measures require a level of black and white specificity. The judgment calls and information along progress notes cannot currently be used effectively. Secondly, because EHR is designed to support clinical care workflows and the data reflecting those workflows can appropriately vary significantly. This limits the ability to reliably extract data.

So there's a great deal of work yet to be done about how to balance the need to support workflow with the desire to collect standardized data. Again, the elements supporting an e-measure should be a natural artifact of the clinical workflow and represent a relatively standard element of documentation.

So the technical aspects, again, I think largely come down to data abundance, but we also haven't mentioned security, that's a critical issue for working with patient data. I know we all know that, but it's important to remember that. But equally for us a magnitude that really exceeds the technical issues are the social and organizational barriers. Key among those is creating trust, being clear about the purpose of measurement and the uses of data. A lot of that aligns with the comments before about being aligned with a larger quality strategy. Change management is not insignificant. The re-framing of roles for both patient and provider, workflow adaptations, and then also this additional issue of just again trying to balance the specification of a major with local and individual autonomy. I think I'll stop there and turn things back. Thank you.

Christine Bechtel – National Partnership for Women & Families – VP

Joachim?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Good morning. Thank you for asking me to make some comments here. My name is Joachim Roski and I'm a managing director at the Engelberg Center for Health Care Reform at Brookings. The center provides data driven practical policy solutions that foster high quality innovative care that is both more affordable and more effective in actually improving health. Obviously the recently enacted health care reform legislation provides a key area of focus for us, seeing to it that we find ways that this legislation can be implemented in the best possible ways.

We conduct our work in a variety of different ways at Brookings, through policy analysis, through data driven analytic approaches and by engaging with stakeholders through consensus processes as well as collaborative work that can lead to solutions that work in the marketplace. We focused on a variety of different areas in our activities, including quality and value and how to measure it, payment and delivery reform, we've focused a lot on accountable care organizations, how to introduce more evidence in health care decision making, all the way from clinical decisions through policy based decisions, medical innovations, state health reform, and health reform implementation.

Over the last several years the center has focused, among other areas, on meaningful use with HIT and developing effective, efficient and scalable means to collect ... electronic data to measure health care performance. Such information, as you know, can support clinicians in improving care. It should support payment reforms and aid consumers in smart decision making. Through those efforts we've worked extensively with physicians and provider organizations, health plans, consumers, employers, representatives of regional measurement and improvement collaboratives, quality measurement experts and others. The Quality Alliance steering committee, which is chaired by Drs. Mark McClellan and Carolyn Clancy, has provided guidance and oversight to these activities to ensure that relevant performance information can become quickly much more available than it is today.

The center has also focused on opportunities to support the private and public sector payment reforms by linking health care system performance to reimbursement schemes. To that end, we're currently working very closely with Elliott Fisher and his team from Dartmouth from the Health Policy Research group. Among others, we have, for example, worked over the last few years with a learning network of approximately 90 aspiring accountable care organizations, within a learning network format and we are piloting several aspects on how to implement accountable care organizations with several accountable

care organizations and their payer partners. As you can imagine, measuring the performance on quality, cost and the experience of care is fundamental to these accountable care organizations, how to link such performance to potential schemes of reimbursement or shift savings, and we've laid out in that context a potential trajectory of how performance measures could be used today and how over time they can become more outcome focused and patient-centered than they are today, relying on a much broader array of data sources.

In order to support progress on making performance results available quickly, because these payment reforms are supposed to kick off very, very soon, much sooner than we are probably talking about today, in terms of making additional meaningful use requirements, how to operationalize those, and so we have focused on activities to more effectively access already available electronic clinical information from administrative data sources, laboratories, internal and external registries, as well as electronic health or medical records. As I mentioned, that data is often available today but it is either not accessed or connected in the right way to compute performance results and to make them more available. So what we've been working on and advocating for is that we need to take full advantage of the data that is available today and use them for the purposes that we need them while we are computing and laying out a trajectory how to make additional more meaningful measures available over time, because some important performance results can simply not be computed based on electronic data that we can access today.

Just to illustrate one of these cases, one of the very vexing issues that we've been working on is, for example, cancer care, arguably one of the prime areas that people in this country are concerned about and to know more about. We have all reason to believe that both the effectiveness and efficiency, as well as the experience of care, for cancer is by far not as good as it could be. So for example, one of the key data elements we do not have generally available electronically to us today is information about the stage of cancer care and other biomarkers that are important. Now, these parameters are critically important for us to determine to what extent evidence-based care is actually rendered because it tees off tiering, if you will, or proper diagnosis of cancer and biomarkers. If we don't have this information available we cannot really determine the quality of cancer care in this country. As I mentioned, in order to plan for a more integrated and functional HIT environment that supports and incentivizes better care, we should focus on harnessing all learning from data that is available today, while formulating how we would like the system to evolve. I think that's very consistent with what we have been discussing this morning.

So, one of the issues that we have been also arguing for is essentially viewing the evolving health care system as a learning health care system and hence arguing for the better use and integration and feedback loops about performance as unnecessary in order to make that happen. This basic premise in our experience at the center suggests a number of key elements we should keep in mind as we set out to improve the electronic availability of data and measures to support patient care, care improvement, measurement, and enable the necessary performance feedback loop.

First, we would recommend that we primarily focus in development of new measures on measures of outcomes and results of care. These can either be broadly applicable across conditions, or examples might include health risk, functioning, and so forth, or they could be specific to some prioritized high impact conditions, be they cardiovascular care or cancer care, as I talked about. You can even imagine how those two might be combinable.

Moreover, we believe that such outcomes should address the quality, the cost, and the experience of care simultaneously rather than one or the other, because ultimately we believe that by a focus on outcomes we will be able to allow physicians, consumers, payers, and others to be much more focused on innovative ways of delivering care rather than not focusing there. Measures of specific clinical practices or measures of mere documentation of a care process itself, such as the completeness of records, for example, we believe we should deemphasize, and ideally, we should select outcome measures that reflect those concepts.

Second, measurement should be patient-centered by reflecting the total episode of care as it is experienced by the patient. What that suggests is that we focus on measuring results across the care continuum and that it should replace measurement approaches that might, as we often do today, focus on very specific segments of physicians taking care of a very particular aspect of an episode of care. We're not saying that that needs to be replaced necessarily, but it certainly needs to be augmented by an approach that actually tracks patient care outcomes across that care continuum.

Third, care coordination management of hand-off and care transitions represents chief areas of concern for many patients and known opportunities for improvement. Hence, identifying or developing suitable measures that allow for an assessment of successful care coordination and transitions not only reflect a patient-centric point of view, but also allows for a focus on a major defect that we currently experienced in achieving ... results.

Fourth, it's hard to imagine a patient-centric view of care that does not reflect patient values, preferences, and other input. Hence, patient generated data reflecting these and other domains must be captured to be able to effectively consider it during the care process, including shared decision making.

Finally, future measures should not only tell us about the meaningful use of HIT ... specific physicians. Instead they should be useful in supporting care decision making processes, payment reform, and consumer need by addressing all of these objectives, to a common, parsimonious set of measures. Thanks.

Christine Bechtel – National Partnership for Women & Families – VP

Thank you. We'd like to do some Q&A. It might make sense for the workgroup members who have specific questions for Fred to start with those, because I know you have a time crunch. But all questions are of course open to response by any panel member who'd like to comment. If you want to either raise your hand or put your tent card up I can start the queue, and how can you not start with Farzad? Go ahead, Farzad.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Thank you for a really terrific testimony that in many ways is quite aligned not only with each other but with much of the discussions that have taken place in the Tiger Teams. A couple of tensions that I want to flesh out, one of them is between the principles that the information that is used for quality measurement should be routinely collected as a byproduct of delivering care, it should be feasible within clinical workflows and information systems. The counter situation is oftentimes on the exclusion side, where you can define the measure in the main using the data that's there. But to know if, for some reason, there's an exclusion, a very particular exclusion to this requires, as I think Paul Tang a couple of years ago they found the number of data elements doesn't scale, for every exclusion you need an additional data element and there's no point at which you get the 80/20 benefit of that.

So what are some experiences or perspectives in how to deal with the exclusion issue? An example might be mammograms, information about whether the person had a mastectomy in the past that was bilateral and whether or not there were lymph nodes removable. That is typically not something that would be found within the electronic health record structured format. Whereas, the age of the person and whether they had a mammogram or not might be more feasibly found in the records. So what are some approaches that you have found or recommendations for research?

Fred Rachman – Alliance of Chicago Community Health Services - CEO

... very challenging issue. I think there are a variety of strategies that are able to be employed now. As you said, the ideal would be if all those data elements were captured and there could be an automatic algorithm. Fortunately there's some that we can do that, so for example when we constructed the foot exam measure for diabetes we were able to capture some elements where if the practitioner recorded them, a foot amputation, as an example, that could be excluded. But in most cases if you outline that's not possible, so we are just using broad categories that a practitioner can use, so a medical reason, a

patient reason, a patient refusal, just very broad categories that work across any measure. That will work to turn off the prompt. It will work to exclude the patient.

However, it's really important that there's some action within the system on that so it doesn't end there. So as an example, if the practitioner indicates that there's a medical reason there should be some way to say what that is and then there should be some audit procedure. I think we never get away from some kind of manual audit even with an electronic system, so that would trigger some review, particularly if that practitioner we can electronically look and see if there's some patterns of exclusions around particular practitioners that begin to alert us that they're excluding everyone medically or everyone is refusing, there's something probably going on underneath that. That's basically the way we've been approaching it so far.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

We've been experimenting with something I think that would be complementary to that. I would offer two suggestions. One is, per measure to identify what might be the prevalence of exclusions, i.e. if, for example, for Pap smears you might have hysterectomies and prevalence, at least cumulatively, up to 20%, 25%, that may need to be a standard data element that comes through.

Number two, I would agree that we probably should not blindly apply measurement principles. One of the technical solutions we've been experimenting with is before any data is used for decision making purposes or more broadly shared, tentatively computer results are shared with a physician. Say we believe XYZ is the case for those areas, where for example, to speak a little measurement speak here, where we don't get a numerator hit out of the electronic data a physician might have the opportunity to say, well, as a matter of fact here's evidence that XYZ was not necessary so that could either alternatively, or in addition to what we heard before, be considered.

Paul Wallace – Kaiser Permanente – Medical Director

I think one thing that we found is the clinician, patient relationship are the key ways to capture the basis of these exceptions but also using decisions for within the electronic health records allows you to do both ... of standardized treatment where standardization is appropriate, but capture the reason for exception when the patient needs an exception. An example would be how we've managed protocol treatment for cancer using chemotherapy protocols where we've developed standardized protocols that are appropriate for two-thirds of patients. What we're finding is that those patients then have very similar treatment within the protocols, but we also capture documentation of why a protocol exception was appropriate. I think the clinician, patient relationship is a very important place to be able to focus on capturing those reasons.

Christine Bechtel – National Partnership for Women & Families – VP

In the queue I have Peter, Jacob, Jim, Tripp and then we'll go to the phone for questions as well.

Peter Basch – MedStar Health – Medical Director

I want to thank the panel for the testimony. This is really terrific and helpful. To start with a question directed mostly towards Fred but obviously I'd welcome the response of others. First of all, I want to congratulate you on your work. It's terrific to see what pioneers in this field have done and keep doing that great work. Part of your testimony caught my attention, and I think it's valuable for us in a couple of ways in terms of its focus on measures and metrics as they relate to patients, but also as they relate to providers.

Specifically, what I'm getting toward as a practicing physician and someone who is attempting to push attention to metrics and measurements in the health system, and I've found that there are typically two speeds of the response: not care or care completely, 100%. The whole issue of non-adherence, and I agree completely that we learn some things from adherence, we learn a lot more from non-adherence, and that non-adherence should not be looked at as a bad thing but an educational opportunity. Depending on how one looks at that, it could be, one, to look at is the metric wrong? Is the way we're approaching engagement with patients wrong? Or is the metric itself as the way we're messaging it

toward physicians perhaps wrong? So there is a question in my comments and the question is, have you thought through the implications of increasing the number and focus on quality metrics in terms of the potential downside of an embrace of 100%?

Now, what do I mean by that? For example, for those of us who are looking at diabetes metrics, we know that we'd like to get most of our patients under "good control." Well, when you aim for good control what are we talking about? If we look at a particular measurement, let's say hemoglobin A1C, we know that if we set that bar too low and we go to a group of people who want to, by their training and nature, achieve 100% that we will harm patients. So one of the things that obviously we play with is well, it's nice to have some people at 6, some people in the 6s and most people below 7, but not 100%.

So that's actually a very difficult message as we begin to make quality metrics transparent and consumers and payers and patients see these on the Web site, where are you at, at that metric, are you at 20%, 40%? The higher the number is the better. Some of us are worried that the higher the number, up to a certain point is better, but beyond a certain point we could be doing harm. What is your experience in your health system as you look at pushing quality metrics to your providers in terms of creating that balance, establishing a shared baseline, but making people aware of the subtleties of non-adherence for some patients is probably a good thing?

Fred Rachman – Alliance of Chicago Community Health Services - CEO

I think that's a really good question. I don't know that I have a total answer to it, except that if we're all using uniform measures we're all going to be struggling with where should we really be aiming. I also think some of the comments about not having the performance measures sit here, like it's not sitting with me as a provider, it's sitting amongst us as providers, patients, health systems, etc., so it becomes a discussion point, a dialogue, it becomes something that we're thoughtful about. Again, hopefully I said this over and over again, we have to be very careful about how these measures are used. They're properly used to guide future investments of our time, our effort, all of those things. I understand it's going to be some kind of scorecard that people are going to use to determine whether they get carried, they have to be very careful for that reason. I don't know if I totally addressed your question. I think the other issue is this exclusion issue. So I think it is important that we have these exclusion categories and are properly able to say when a measure does not apply to a particular client and that we're able to watch that in a very objective way.

I apologize that I have to leave. But I will hate myself if I don't make up for one deficiency in my conversation, which is that the whole issue of standardization of data, which we're beginning to do in the medical realm, but as we move to patient factors and other social factors, nursing concepts, mental health, etc., it's a whole new world. So that is an area I think we really need to be paying attention to is how we're going to create structured, consistent data elements so we can include all of these in our care. The second piece is we're not even doing that great with the ones we have, especially as an example, lab data, where it's one of the biggest struggles that we have not held reference laboratories properly accountable for reporting standards. So I really didn't mean to address the issue of standardization of data. Sorry. I have to run.

Christine Bechtel – National Partnership for Women & Families – VP

Jacob?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

This was a Fred question, but he's still in the room so he's fair game. The question, Fred, very quickly, if you want to nod or shake your head, you talked a lot about clinical decision support and quality measures more than the other folks and I wonder if you could, or maybe the others could, distinguish what's the difference. Do you see a tie, should we Velcro these more tightly together in future work?

Fred Rachman – Alliance of Chicago Community Health Services - CEO

Again, on my way out the door, so I really do believe that the purpose for quality measures is that they are actionable. One of the difficult experiences, our early experience in community health centers with quality measures that came through ... management systems was that we would get all this information about what needed to be done for the patient a week or two afterwards or a month afterwards and the opportunity to do anything was gone. That's why we've elected to make that quality measure, layer that directly into the system at point of care. I do believe that that's important, with the caveat that hopefully, I made the point that where we are is that the quality measures are less stringent than the actual care recommendation. We're going to have to balance that out because it's very difficult to drive consensus at that level of astringency. The quality measure has to rest within the recommendation and so that's the challenge. Since I don't have an answer I'll leave the room.

Christine Bechtel – National Partnership for Women & Families – VP

Any other comments from the panelists, or responses?

M

My thought is that I would think that the quality measures or the areas that quality measures cover is a subset of all the clinical decision support that should be acceptable to the physician, meaning that arguing for a parsimonious, small set of measures that might cut across as many physicians as possible, it would be hard to imagine how you could improve them without effective clinical decision support. That being said, there are many other areas where physicians might be able to benefit from decision support that are not directly covered through routinely collected and reported measures that are tied to payment reported to consumers and so forth.

Paul Wallace – Kaiser Permanente – Medical Director

I think that maybe to build on the comments made before, I think one of the roles of decision support is obviously to engage the clinician in the numerator events, but there's the complementary aspect of decision support which is to give the clinician some say in the denominator event and to basically be able to provide input about the appropriateness of the measure for the patient in front of the clinician. That could obviously be adapted also to the aspect of decision support for patients helping to determine not only appropriateness for a numerator but also for a denominator.

W

I'd just like to address briefly this business about interpretation of performance that's not at 100%. I don't think we've mined the potential for helping people understand what these measures mean and how to help people use them in decision making. People are extraordinarily educable. I think we just haven't done sufficient work in education around the interpretation. People are not accustomed to using these types of data. We know that consumers are the least likely to use them, but if we're serious about having public reports with measures to support decision making, I think we have to do more to learn how to help people interpret. I think that there is an opportunity to help. People know that perfection is very hard to achieve and sometimes it's not absolutely desirable in every case. That's not a concept that's so out-of-the-box that most people can't handle. I think we just have to do more research and figuring out how to convey information and to support interpretations.

M

This is I think we've made progress that we've thought of care as being 100% appropriate if the target ... being 100% within a particularly narrow definition.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Just very quickly on that, I think that's the standard is that 100% of patients get offered the intervention, have an opportunity to understand it, and have their decision recorded and acted on. I think at that level it is 100%. Then how that plays out over time will undoubtedly change regarding how many people accept which interventions. But my question is about process and outcome measures.

So the first background statement, obviously the end game is patient outcomes, decreased days out of work, increased activities of daily living, increased instrumental activities of daily living. The issue with that is most pertinent at the individual level. Every clinician knows, and most of the rest of us do, that lots of patients end up doing well despite suboptimal care. Some patients do badly despite care that is at least to the level that we can measure it at this point, it's pretty narrowly optimal. For the individual patient to understand the quality of care that they have received and are receiving process measures will be absolutely critical. By process measures I'm including patients whose blood pressure is managed at an appropriate level and those sorts of things, that sometimes are called outcomes measures. But I don't think patients register those as outcomes.

The second level is that and exclusively focus on outcomes will and in fact already has been documented to provide an incentive to the professional health care team to avoid patients who can be predicted to do badly more or less independent of the quality of the care they receive. There have already been published reports of this happening, process measures, high quality process measures that are really validated to be causally connected to patient outcomes will provide a check against that tendency.

The third is that care coordination measurement will be largely impossible without process measures. Then finally, every organization in health care and elsewhere that is passionate about high performance and high quality and efficiency manages their processes to the death, manages every detail about them and certainly in our organization, and Kaiser can tell you the same thing, we have hundreds of process measures that we manage all the time to achieve those outcomes.

So with that rather long preamble, sorry, I'm interested to just probe a little bit further obviously into your understanding of the interplay between process measures and outcome measures, particularly Joyce and Joachim, I think.

Joyce DuBow – AARP Public Policy Institute – Associate Director

I know it's not fashionable to agree with what you just said because outcome measures are the darling concepts of the 21st century. But I happen to agree with you. I think that if we know that these processes have a known relationship to an outcome and that they are necessary in delivering appropriate care, they actually could be very helpful in engaging patients to understand what the processes they ought to be getting. It's the pull-push kind of thing. If it doesn't happen, why not? I think they are very important, actually. I'm old-fashioned. I don't think there's anything wrong with them as they are. The problem is we don't always know what processes affect the outcome. I think that's the challenge.

So at the moment we have a bunch of process measures. There was an article published last week, I can't remember where it was, about some process measures that didn't have a relationship to hospital measures, that it didn't have a relationship, they were mortality measures, that those processes did not affect mortality, whatever it was. We see a lot of articles about this. I think we need to know and need to be careful that we don't have a mess of process measures that are just out there. These should be important processes that are related. But I do believe that if patients knew about the processes then they would be more engaged, they would look for these.

I also think that there are structural measures. I think Fred mentioned structural measures. Patients are interested in structure. Again, they have to be important. I don't think we want to waste resources on measures that don't yield improvement, but the range of structured process outcomes wasn't a bad paradigm when it was first designed. I think there's some utility to it.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Jim, obviously your comments are very thoughtful and require careful consideration. My take is as follows: if we're looking for a parsimonious set of measures, be they 20, 50, something like that, over the next few years to be used for meaningful use regulations, to engage physicians, to use for payment purposes and so forth, we should pay close attention to focus on those areas that simultaneously engages the public, the payers, the providers, in delivering better care. As you said, there are arguably

hundreds of processes that might drive individual outcomes, and so one theory might be well instead maybe we should be building modules within particular conditions that line up all the relevant process measures that we know of today plus an outcome measure to measure something.

Ultimately, I think we need to ask ourselves the question, how much measurement can we stand to put on the system? So a couple of thoughts about that. One is, you mentioned the issue of if we are focusing, and by the way I'm not arguing for the black and white continuum here, but probably over time moving to more outcome measures, mostly because we can't even measure the outcomes today, in terms of providers having incentive to not treat particular patients where outcomes might be very difficult to move, there are probably alternative ways that you could track or develop how to track if that is a phenomenon that's in place.

Number two, I would for sure argue that an immediate outcome such as blood pressure readings, cholesterol, and so forth, we should consider in the realm of outcome measures. Because some of the outcomes, be they mortality, morbidity, obviously are driven by multiple factors and might be hard to use them in any kind of accountability construct when there are so many other drivers that we don't even know how they're going to be impacted by mortality.

So to sum up, I think in terms of getting to a parsimonious set it's hard to imagine how you could comprehensively cover conditions if you have a predominance focused on process measures. Ideally, as Joyce and others have mentioned, if you can find those processes that are major drivers of the outcomes those obviously would be good candidates to include. But as I think you suggested and others suggested, sometimes we don't know that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

... when we think about the balance sheet for outcome measures a critical issue too is that outcome measures arguably are more likely to drive innovation, where process measures may walk you in to what's already known. So balancing between process and outcome is important and we want to encourage innovation.

Christine Bechtel – National Partnership for Women & Families – VP

Tripp?

Tripp Bradd – Skyline Family Practice – Physician

I want to thank you all as panelists for contributing a lot of information. It's been very helpful. My question is going to be revolving around patient engagement and HIT sensitive engagement as in Web engagement. I'm a family physician and I used to do womb to tomb, that is I used to do OB, but now I do crypt to crypt. As I get closer to the crypt my interest in geriatrics has increased, as most people's does with age, and I'm glad you're here, Joyce, to comment as a representative of AARP. But that's been one of our challenges. We've had a dynamic Web portal since 2003 and engaging our outliers, that is our geriatric population, has been quite a challenge. My question to the panel is how do you engage people to use the Web given an infrastructure that works and they have the equipment and all those other variables, and then how would you measure it?

Joyce DuBow – AARP Public Policy Institute – Associate Director

First, I don't think AARP is going to adopt the term "crypt to crypt." I've never heard that one. But in any event, I think that we need to take into account what happens to people as they age. It's more challenging to use the Web. It's more challenging to use technology. In addition to cognitive impairments you have a loss of confidence in lots of places, you have issues of vision, you have greater disability, you're just much more disinclined. Many people have caregivers to help them and I think that that is an obvious solution in part. I think that the reality is that we will have a segment of the population, the older population in particular, who will not use the Web and that we will have to have alternatives, that we cannot rely exclusively on the Web as a means of communicating and engaging patients. There has to be other ways of doing it. There cannot be a one-size-fits-all.

I do believe that I remember seeing Pew data that show that among the higher ends of the age scale that the adoption of technology is actually more rapid than it is in the younger population, where it's probably very, very much entrenched. But as I say, I think that we need to be realistic about the penetration of IT adoption among old, particularly very old people. I don't see it. I also think that it remains to be seen what happens to those of us who are aging and accustomed to using technology, what happens when we actually become much older and whether that inclination and that interest is going to remain. I frankly have my doubts.

So I think that we need to figure out multiple strategies, particularly for dealing with people who are older. For people who have health literacy skills, we can use technology for that. But people who have poor decision making skills, minority populations that are not exposed to the digital world, we have to have multiple pathways to engaging patients. It can't be only through the Web. That's clearly the easiest, it's probably the cheapest, it's probably going to hit the most people, but it's not going to hit everybody. We need to be creative about thinking of other solutions.

Christine Bechtel – National Partnership for Women & Families – VP

I know that, Jim, you had a quick comment on this topic. We're going to go to the phone and I know Peter and Farzad will want to come back to the outcomes issue.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

We serve 40 counties in Pennsylvania that are old, rural, underserved, undereducated, poor, whatever the other categories are, and our networked PHR that enables patients to be more active in their care processes serves 157,000 patients, about 30% of the patients for whom we have some kind of ongoing relationship. Patients have to sign up for it, we didn't sort of mass sign them up. The largest group of users is people between 49 and 64. The next largest group of users is people over 65. You're right, the fastest growing group of users is women over 65.

We had an 82-year-old woman send us an e-mail and said, I couldn't believe it, I was 5 states away, I got dizzy, they sent me to an ED. I opened up my record, I could show the doctors in the ED there my labs, my meds, my problems, my allergies, and they said there were a whole bunch of tests they didn't have to do and they could take care of me much faster. We published a study of patient preferences for communications and people on the networked PHR liked electronic modes of communication better than our doctors did at that time. So certainly it isn't everybody, but there's a large and growing group— Oh, and the one other thing to say. The CHESS program done by Gustafson at the University of Wisconsin, a very careful, well done study, he documented that low health literacy people benefited more from this kind of system than high literacy people even though they benefited and liked it. So if it's done right this actually presents us the opportunity to reach out to people who we have largely missed before.

Joyce DuBow – AARP Public Policy Institute – Associate Director

I think the issue of "done right" is really the emphasis. If we have these one-size-fits-all Web sites where you just expect everybody to click on—but if they are customized I think it's absolutely right about people with low literacy skills, that you can adapt to technology. I think there are other technologies besides an EHR, by the way, that are hugely important for people who are living in remote areas, living alone, home monitoring, the range of opportunities are enormous. But as I say, I think that that costs money, it takes a lot of skill to be adapting these technologies for these unique and specific uses, so I think we have to be realistic. I think there's enormous opportunity and I think we'll learn a lot as we progress, but I think there is going to be a piece of the population that is just going to be out of reach and we need to think of other ways to engage them. That's all I'm saying. I don't disagree with you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think it's also important for us to characterize what's the patient's preferred interface. Their preferred interface may be paper or another person, but their social network almost undoubtedly has some

connection to electronic media. So a lot of the ways that we reach seniors may be through their family members or through paper, but the foundation of that is still the HIT.

Christine Bechtel – National Partnership for Women & Families – VP

So, questions from workgroup members who are on the phone?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I have a question. One, I want to thank the panelists for really an outstanding testimony. It's very thought provoking. I have two areas to offer a question or maybe something to test out with One is the ... made by Dr. Rachman, and I know he had to leave, but this whole notion of alignment of measures with essentially with clinical guidelines, i.e. what the physician is trying to accomplish. So the question arose about what do you do when it really should be 100%. I wonder if we could take advantage of ... mortality or morbidity, is to observe ... so that's a I'm not saying everybody has to live forever nor does everyone have to ... 100%. But there's a certain percent of diabetics in a population that should be ... predicted that might be one way to help normalize this and ... so everybody could be 100%.

One example of this was in the old days before CT scans you were supposed to operate on people who you thought had appendicitis that have "x" percent of false positives. If you did ... you were missing some. So that same concept. So I'd be interested in what the panel thought of that.

I'll add a couple of other data points. Non-adherence was another concept that Dr. Rachman brought up, and I think it's really important because one of the studies that I remember had a long-lasting impact on me is one done by Alan Morris at the University of Utah where they, through all the consensus process with experts tried to come up with alerts or clinical decision supports that matched the consensus guidelines. The important thing is they captured why didn't you follow this rule, this decision support, and out of the gate despite the consensus guidelines they only were able to capture 45%. In other words, 55% of folks disagreed with it and they explained why that vastly over time using that input, and that was his point, you could quickly get not to 100%, but let's say in the 90s.

To make a comment about the question that Farzad raised about exclusions, one of the ways that NQF is trying to deal with it is to ask people in their submissions to provide some kind of sensitivity analysis to say whether that extra exclusion is going to add a whole lot statistically, because as Farzad pointed out it's really costly to get that information.

The second area which I think Christine mentioned we're going to have more questions about is this whole process versus outcome. I think there is process and then there's process. Maybe the least constructive process measures, whether you have written documentation, yet other intermediate outcome measures such as, you often mentioned A1C, blood pressure control, or LDL control, are useful and the studies that the evidence has linked it very closely to, to longer term outcomes. The final outcome I'll just drop for comment is the outcomes that patients care most about is, well in addition to mortality, I guess, but your functional status. Am I better off today than I was before such-and-such was done or I did such-and-such? So maybe those two areas, this whole alignment of measures and the clinical guidelines and this whole process ... and are there other ways that are closer to outcomes?

Christine Bechtel – National Partnership for Women & Families – VP

So thoughts or reactions from the panel?

Paul Wallace – Kaiser Permanente – Medical Director

Maybe I'll just share my reaction. The guideline issue, I think it's always important for us to remember that guidelines are developed as population management tools and the job of the clinician and the patient is to figure out appropriateness. So the measure needs to reflect both the character of the guidelines but also the ability to determine appropriateness. So I think that the credibility of outcomes is going to continue to require us to struggle with that and I think we've talked about ways that the EHR actually gives us the ability to do the ... as being true to the population measure while ensuring that it's

appropriate for the patient in front of us. Frankly, that was almost impossible to do in a paper-based world. So I think we need to continue to figure out how can we actually leverage that ability to actually live in both of those—

Christine Bechtel – National Partnership for Women & Families – VP

We are almost out of time for this part of the agenda, though we got started late so I think we should keep going. I'll just ask folks to be parsimonious in their comments and questions. Other folks on the phone, other workgroup members on the phone with questions? Okay, let's go to Peter.

Peter Basch – MedStar Health – Medical Director

My comment primarily ... somewhat to Joachim as well, and I'll start this as I did my other one with some comments, and then I promise I'll eventually get to the question.

One of my hats is as a primary care provider, and I can certainly personally attest to in my own practice and with those of my colleagues as to the wisdom of your remarks, Joyce, in terms of patient engagement. In addition to looking at poor performers in our system, we're also looking at a group that I call the ceiling ..., those who are performing so consistently above any expected metric that we wonder how they do it. To a person they all do it by having tremendous patient engagement activity and they will readily attest, as I will personally, that one can only get to a certain level with preventive chronic care measures. If you're just doing things to someone, but together with shared goals and so forth we actually don't know where that ceiling is. So I applaud your statements and certainly resonate with that.

Now, with one of my other hats, which is resonating with one of Paul's statements about disrupting innovation, which is a physician lead for our EHR implementation, I can say that physician engagement does not equal physician satisfaction. In fact I wonder whether I'm doing my job effectively when I don't get complaints from hospital presidents and VPMAs and I know when the number of complaints go up that I'm probably hitting the right nerves about changing behavior and changing processes.

So the question part of this monologue now is, how should we think about balancing measures of patient engagement, patient satisfaction, with what we know to be, as has been said by others, a disruptive process and a process that sometimes causes some degree of discomfort along the way. For example, as a primary care doc most of my chronically ill patients have diabetes and most of my diabetics are out of control, lifestyle issues, diet, overweight, lack of exercise, and a lot of what we do is focusing on things that people don't necessarily want to change. How should we balance seeking to measure patient engagement when our goal is not necessarily to make people happy but to engage them to help them to make themselves healthier? Because clearly we want to achieve that aim, we want to find out from patients their perceptions of care, but we want to be looking, at least in my opinion, at the longer view, which is more outcomes focused, but obviously we don't want to blind ourselves to the people that we work with in achieving those outcomes.

Joyce DuBow – AARP Public Policy Institute – Associate Director

In truth, I don't know the answer to your question. We're talking about changing behavior. I have a lot of confidence in what a trusting relationship between a patient and a physician can accomplish. I think if there is a trusting relationship a lot of the barriers just fall down. I think the challenge is creating opportunities to create that trust. We have a system right now that really doesn't do that. The churning in insurance coverage, for example, that yanks somebody from one network to another just creates upheaval and discontinuity with respect to opportunities to stay with one practitioner and develop a long-standing, trusting relationship. I think that a lot of the stuff around direct to consumer advertising, if there were a trusting relationship could be accomplished. The stories that you hear about physicians who say, well, you know patients just insisted on it, I think when you hear somebody's opinion and it's an opinion that you trust because you have a long-standing relationship, you bring to it a different attitude. So I think there are a lot of things that play into this.

I think also that the current physician focused culture needs to change. That has to go back to medical education. There needs to be a reorientation. We need to teach people to do motivational communication, we need to teach them, medical students, nurses mostly are okay, but we need to teach people that there is value in engaging patients. Some people don't care. Judy Hepburn has done some interesting work, I think for Commonwealth, that has looked at the link between patient activation and physician views about activation. I think that's a very important thing to understand.

So I don't know the answer to your question. I just think there are a lot of things we need to hit on and change and they won't happen overnight. The reason I think patient engagement is so important in providing information to people and encouraging them to assert themselves and insinuate themselves into these partnerships that we're trying to encourage is to stimulate a new attitude and a new relationship. So I think it's a very big question and I think there are lots of things to do and I don't expect it to happen overnight. But I think that the more we talk about the need to have patients' views be taken into account and the need for patients to pay attention and to ask questions and to assert, the more progress we will make and move forward.

M

A comment on the outcome process question, of course I agree with both sets of commenter's. I wonder if a way to understand this differently instead of it being a zero sum is, Joachim, one of the things your comment didn't reflect is how with electronic health record enabled quality measurements the paradigm shift from quality measurement being done to people, to providers, to providers being able to use those tools, as Fred was saying, to do quality improvements in a very short cycle within the wrong practices. It's not an issue of someone giving them, here are your quality measures. Even with a short legacy it's an issue of them being able to have control over the quality measurements and to be able to drill down and to be able to parse out what's happening.

One of the fundamental goals, and we'll come back to this, the fundamental goals of this exercise is to come up with a set of really parsimonious measures that are broadly applicable and yes, outcome oriented, although as was pointed out sometimes what the outcome is, whether it's patient experience or care coordination, might seem more processes to some. But even if you take a headliner measure that is more outcome-y, right, we did this with Neil Calman, we said if a test, I think it was lipid control, for all people who have whatever set of conditions if they had a test and you were only the numerator if you had a test and the LDL was less than a certain amount, so if you didn't have a test it also counted against you. Now, one might say but that doesn't let them understand where the process broke down. Was it that people weren't coming in? Was it that people weren't getting tested? Was it that people weren't being controlled? In a sense the headliner outcome measure doesn't care, but you can be darn sure that the providers care, and they then created a set of five specific process measures for their own use to figure out where the process was breaking down to try and improve that.

So I think rather than have the accountability measures or the public reporting measures, let's lay out all the processes that go into that, and are people getting tests on time and are they being seen, and are they controlled and are they taking their medications, to focus those headliner measures on the outcome and to allow that innovation around the processes and to allow the providers to drill down into their own processes to improve their processes. So the difference between quality measurement for public reporting, accountability, and so forth versus quality measurement for quality improvement within those sites.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Can I just make two comments, quickly? First, is that I agree with you. When this is done in the context of the health care teams, docs, nurses, case managers, patients, everybody saying this is the way we're going to work together and the electronic stuff reminds us, then you go from why are you sending me this stupid alert, to thank you, I almost missed that. So I think that's absolutely true.

The second is I think we need to be careful about language. If we say patient outcomes is what we're focused on and we go to Congress or the public with improved LDL, I'm not sure that's what they mean by outcomes. So I understand we can call that outcomes, but when I go buy a car outcomes is a car that's got better mileage and more comfortable and quieter and more durable than the last time I bought one and it cost less. Not anything at all about intermediate processes that Toyota or Honda are executing. So I'd take some care there.

Christine Bechtel – National Partnership for Women & Families – VP

Point well taken. Eva?

Eva Powell – National Partnership for Women & Families – Director IT

I regret that Dr. Rachman isn't here because my question's really for him. But I'm curious, Joachim, I'm directing this question at you, part of what I think Dr. Rachman was getting at is that outcomes are dependent on much more than the health care system. What so intrigued me about his comments was this concept of measuring across programs, including social services and other types of things that aren't typically considered part of the health care system. I know from having been a hospital social worker for ten years that you can have a plan that's very evidence based and according to clinical quality guidelines and it really isn't a quality plan and it's not quality care because it's not consistent with what the patient and their caregiver are able to handle at home. I think we take it for granted that care is easy sometimes when really our care at home these days is pretty complex.

In my mind I think Dr. Rachman was getting at this concept of moving beyond the health care system to measure quality, and I'm curious as to whether that's part of what you've been looking at thinking about ACOs. When I think about the likely success of an ACO I wonder if that success might be even greater, or the potential of that success might be even greater if there are measures and ways of holding so it's accountable for connecting to resources and supports that are outside the health care system.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Obviously the answer to that question is yes. We do know about many outcome measures that the health care system may affect 10% or less of the shared variance, if you will, of affecting that particular outcome. So one question that I think we need to come back to is over and over and over what is the ultimate reflection of where many of these issues might come together and what might be a representation? Because I think as Farzad laid out and as Jim laid out the factors that might impact an outcome could be many fold, tens, hundreds of factors that might drive a particular aspect, and the more of that we can measure, the better. How many of those aspects we should be measuring for to use for public policy purposes and so forth I think we need to ask ourselves and then asking organizations, figuring out how do you build a mirror system, if you will, in your organization that could measure many of the underlying factors that might drive that and would help you, the organization, set free your innovative potential to affect these underlying factors in the most possible way. So long story short, I agree with you, we should be capturing that. How that should be reflected in an accountability framework I'm not 100% sure.

Joyce DuBow – AARP Public Policy Institute – Associate Director

Could I just make one comment about that, since I actually addressed that too. I think that the idea of linking to community resources is obviously not original. People who do post acute care and long term care have been talking about this for years, and everybody in Healthy Aging knows about it. But in the medical system and in the accountability system it's less familiar. We're just not talking about it as much. I think measurement and public accountability measures go through stages and I think that over time it will be in the best interest of an ACO to be figuring out how to link to community resources, because they're going to see that it enhances care and it does the good things that we know it will. I think in the short term, however, it speaks to thinking about measurement in this area because it's new. It's a concept that's not addressed.

I think we need to think about measurement that way. When it becomes same old, same old we can begin to become more parsimonious, but this is an area that is not yet well integrated and it hasn't really

been raised to the level of our conversation. I understand what Joachim is saying, but I think in the short term we ought to be thinking about measurement in that area and we ought to be sure that the records can have the capacity to get those information into link and of course it deals with interoperability and all the rest. So I wouldn't say that it shouldn't be part of it quite so fast.

Christine Bechtel – National Partnership for Women & Families – VP

The last question to Helen.

Helen Burstin – NQF – Senior VP, Performance Measures

A very brief comment on the outcomes process discussion of course. Just one point, which is that I think the issue is not so much that we can make this a black and white issue. There are some processes that are critical, that are so proximal to the actual outcome you're interested in that not looking at those very carefully I think is something we really shouldn't consider.

The second thing is that there are actually some process measures that actually are in some ways currently the only way to get at some of the key priorities we've talked about. Overuse, of course you want to be able to look at rates of inappropriate scanning, for example. Of course you want to be able to look at some of the key transition issues that really are going to be more process measures, so not to throw the baby out with the bath water, just to consider process measures proximal to outcomes are critical. And the last point is just that sometimes there are real opportunities for us to take groups of process measures and create really important composites that allow us to get a comprehensive view of ... and oftentimes those are a mix of process and outcomes. Again, I just don't want us to lose those concepts.

Christine Bechtel – National Partnership for Women & Families – VP

Thank you. Here's what I'd like to suggest that we do in terms of Actually, first I want to ask Paul Wallace, are you able to stay on the phone for most of the day today as a workgroup member?

Paul Wallace – Kaiser Permanente – Medical Director

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Fantastic, because I have a question for you that will come up later. What I'm going to recommend that we do we had a break that was scheduled that we of course we went right through, and we are scheduled to go until 1:00. I'd like to recommend that we go ahead and keep going with another two Tiger Team presentations and then do a quick ten minute break that way that will get us closer to the 1:00 hour. Because I want to be sensitive to the fact that we're not providing lunch, so it might be better to have a snack time in about an hour. Then I know that we've got about 30 minutes for public comment. We typically don't need all 30 minutes so I'm going to take that risk and use some of that time to make up for it, so without objection that is what we will do.

M

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Christine Bechtel – National Partnership for Women & Families – VP

Yes, yes, yes, do your thing, of course.

M

Do what you have to do.

Christine Bechtel – National Partnership for Women & Families – VP

Although you guys let me ask you to listen for about five more minutes, though, because actually this is an important part of the time. You know what, they're absolutely not listening, so I'm thinking that we're

going to actually take a break right now. I think we have anarchy. That is okay. So in ten minutes we'll be back.

(Break)

Judy Sparrow – Office of the National Coordinator – Executive Director

David Lansky, are you on the line?

Christine Bechtel – National Partnership for Women & Families – VP

He's not, I don't think.

Judy Sparrow – Office of the National Coordinator – Executive Director

He's not? Okay.

Christine Bechtel – National Partnership for Women & Families – VP

He'll be back on.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay, I just wanted to ask something. I didn't want to say anything. But Christine I'll turn it back over to you.

Christine Bechtel – National Partnership for Women & Families – VP

All right, terrific. I've got a slide deck here to go over actually some ... comments. So let me say a couple of things about the process going forward from today. From this point forward in the meeting, again, our goal is to come up with a set of recommendations to go back to the full HIT policy committee that will inform ONC's development of the RFI and the subsequent RFP. So to facilitate that we're going to hear from the Tiger Teams who have broken out and done the hard work and thinking to identify the measure concepts and gaps. We will hear from the leads of each Tiger Team as to what they came down to. We'll have about ten minutes for Q&A after each presentation, and that's a good time to raise any concerns or issues or talk about the things that you think are particularly important.

We will also have some time towards the end of the day for a full discussion of everything at one time, as opposed to going through the individual teams. So we will then ask the staff to revise some of the elements that you actually have in your packet. In your packet for each Tiger Team you have two things. One is a set of slides that summarize their recommendations. And then the second is a more detailed piece that explains the measure concepts and recommendations in more detail. So after today, and based on your input, staff will go and revise the recommendations and we'll circulate them via e-mail based on that work and then ask for your input and approval through that process before they go to the full health IT policy committee in November. As part of that we, as you'll see, have some work to do around parsimony and so I'll talk about that in a moment.

In terms of guidelines for our discussion today we asked the Tiger Teams— Actually let me stop and turn to Farzad and ask you first, I'm sorry, if you want to say anything at this point.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Sure. This has been terrific seeing the work on the Tiger Teams, the experts who have come together in each of these areas with passion and incredible depth of knowledge for that area. One of the things that we do want to bring the process back to and make sure that we don't fall into the trap that others in the past have fallen into is leading to a proliferation of measures that are highly specific to the domain area, rather than as parsimonious, as broadly applicable as possible. There's a balance there.

The other thing to highlight in terms of what the purpose of our exercise here is, as Christine pointed out, is to identify critical gaps. This is about the next generation of quality measures and making sure that what we come up with is truly new, different, they're really what we want at the end of the day, and to go

forth with boldness while making sure that we also recognize and appreciate what is available today in the near term. So holding simultaneously the vision of the future and the priority gaps for development, as well as the near term, and recognizing fully that some of the work in terms of the more ideal measures isn't going to be ready in six months. But that's okay. So one of the things that we are going to emphasize in the course, I hope, of the Tiger Team discussions is what are the core concepts that we want to really get at and then a sense of what is the distance between our ideal vision for those concepts and what is available today that can be addressed through the activities over the next couple of years.

Christine Bechtel – National Partnership for Women & Families – VP

Terrific. That's a great segue to talking about the points you see on the slide here which are the criteria that we ask the Tiger Teams to use in doing and going about their work. So the Tiger Teams were asked to consider a number of concepts and criteria and I think it's important that we bear these in mind today. Given that the work proceeded in a series of individual teams, this is a good time for us to then be pretty focused on making sure that what those teams have produced comport with these criteria and that we can begin to achieve some parsimony, as Farzad talked about, across that work as we hear it presented today. Of course we always invite Farzad and Josh and Tom to chime in and ask the tough questions so that we make sure that the recommendations we've produced back to the policy committee are the most utility for you.

The criteria include, what's the state of readiness of the measure, whether or not it is HIT sensitive, meaning that it's built into the EHR systems with the implementation of relative HIT functions, we heard that from the panel this morning actually as well, ... parsimony has the potential for improving population health or reducing burden of illness, supports health risk status and outcomes assessment, and enables longitudinal measurements. I want to say as a member of the full policy committee we had a number of discussions, and I know Paul Tang is on the phone as well, in the last couple of weeks in the full policy committee about the need to really focus on outcomes and so I think our discussion earlier today was really helpful in forming our thinking about what we mean by outcomes and how we want to balance outcomes with important process measures.

So what this and the next couple of slides do, and we won't go through them in detail, is give you a sense of the work that was produced by the Tiger Teams, so this is an example of the measure concepts that the efficiency group worked on, and their overlap with other groups. So you can see that, for example, readmissions is something that would fall squarely in the domain of both efficiency and care coordination. You can see that use and availability of services that promote healthy lifestyles falls into efficiency, population, public health and patient family engagement as well. So we asked the staff to do this overlap analysis for each of these areas that you see here, and I think the important work going forward, and we can accomplish some of it in our discussions today, is to really look at those areas of overlap and decide, because there's overlap in multiple Tiger Teams, my guess is that that's an indication of something that's really important and parsimonious for us to consider including as a measure concept. By the same token, if it is something that only falls into one category, it's something we may want to take a look at under the name of parsimony.

Any questions before we jump into the individual Tiger Team summaries? Ahmed?

Ahmed Calvo – HRSA – Senior Medical Officer

Yes, I have a question. Maybe let me put something on the table up front, because I want to make sure that we don't get caught in a blinders kind of mentality. Helen brought up composites earlier today and I want to make sure that we think about not composites just as a composite measure, as an all or none kind of whatever bundle piece, but to shift gears into a composite index mentality, the notion of taking personal health records, electronic health records, and community health records to level maybe public health ... population health and factoring them together, so relationships and algorithms, some way of thinking about all of these measures that exist whether they overlap with the different Tiger Teams, etc. I don't think it's going to be enough to get to a parsimonious point of view.

We ultimately have to shift to an index mentality, a national quality index or something that relates to different sets of resources of data to a modifiable index in the future so that we're not stuck with the current data measures or weighing of any of these pieces. But if we just come at this, in my opinion, just from a "what exists" set of measures and composite measures conceptually, then we're putting ourselves in a box, which I think is not doing the nation the best service.

I just want to up front say that we really do need to think outside the box and we're going to talk about these critical gaps piece and where we're really trying to get to in the long run, and designing with the end in mind and some of the general concepts from the beginning. So I would encourage us to think about the different Tiger Teams' presentations not from what currently exists as measures only, but how do we evolve that through use of the HIT algorithms, i.e. get to composite indexes, etc., so that we can then make a breakthrough on regardless of what any one piece of the components might be included in ... because it needs to be given change going forward.

Christine Bechtel – National Partnership for Women & Families – VP

I think that's actually an important concept. I'll remind folks that part of the work that we asked the Tiger Team to do was to actually not focus on measures but really to focus on measure concepts. So that, exactly as you're talking about, in the context of the RFI and in the subsequent RFP the kinds of measures that can be developed we're not necessarily taking a position on is it an episode of care, is it a composite, or what is the structure or the nature of the measure, but rather what are the important concepts that we want to measure, what problems are we trying to solve and then asking the larger community to back into the thinking around how you best do that in a parsimonious, longitudinal, very rich, multidimensional data source kind of way. So hopefully that helps. Sarah and then John.

Sarah Scholle – NCQA – Assistant Vice President, Research

Is our task today to try to take these measure concepts and come out with fewer? What do you want at the end of the day?

Christine Bechtel – National Partnership for Women & Families – VP

I think that's a fair question and I'll answer and then I'll ask Tom if he wants to add to it. I think we should, and I'll go back to the slide, I think we should, where we can, challenge and question the number of measure concepts, for example, and the ways that we might build bridges between Tiger Teams to be more parsimonious. But at the same time this was thinking that was absolutely done with a lot of input from a variety of experts that I think is very valuable, so we should ask questions. But ultimately at the end of the day we're trying to come up with a set of recommended measure concepts for the policy committee and ONC to consider that fit these criteria that you see on the screen that could have measures developed or evolved for meaningful use. Tom?

Tom Sang – ONC

I think the Tiger Teams have been working in separate groups so I think this is an opportunity for all of you to actually give input with a very, very critical eye, based on the discussions we've had. So we hope all of you can actually give input and perhaps going from 40-something concepts to reduce it to the level where it's going to be extremely meaningful for us and based on all those features that we talked about, so yes.

Christine Bechtel – National Partnership for Women & Families – VP

I love this group. This is completely unruly, like me. So I'm going to ask, are there any actual questions going forward before we jump into the discussion? And then we can debate approaches and whatnot later. Yes, Peter? Yours is the next question. Okay.

Peter Basch – MedStar Health – Medical Director

My question is, in this venture, and I get the measure concepts and I appreciate that, at what point in the process, and the answer might be not here but somewhere else, do you want those of us proposing concepts to also editorialize on the concept in terms of the implications? What I mean by that, as we

propose certain measures, certain measures fit along nicely with optimal or meaningful use of HIT. Other measures actually begin to point more toward dictating a new standard of care, new duties, new work, that might actually push where we are in terms of expected physician workload and where physician payment model is now, to somewhere beyond what is perceived as reasonable.

One of the things that I always try and remember is within this room we're all true believers and we're all kind of walking in an environment that has a different level of gravity than most of those who are not using these tools yet. And at what point do we need to be sensitive to these are great ideas but I'm concerned that if we push these for stage two that we might take the people who are just beginning to buy into the concept of maybe this EHR stuff isn't as bad as I thought it was last week, to oh gosh, I see where they're going with this and now I understand that \$44,000 will buy me a system but my entire life will be based on until reimbursement catches up with where we're headed. Do you want us to think about that or is that going to be done at the level of CMS, HIT policy committee?

Christine Bechtel – National Partnership for Women & Families – VP

Yes and you guys should answer this. That will happen in the context of developing the RFI, that will happen at the agency level, and that will happen in the public comment process I think as well. But I think that's out of scope for us today, is that right?

M

We stop short at the concept level because we really want to hear from the external environment and all the stakeholders to see exactly where the buckets of measures are in terms of what's being used out in the real world. If we come out with 30 concepts or 35 concepts we go out and ask all of you who's using real live systems what are the measures that are actually being used that could be applicable to this concept if those measures are not HIT sensitive, what are the measures out there that could be retooled to fit this. And if we don't have anything for the first two buckets, then what are the aspirational measures that need to be developed over the next two years? So we hope to have measures for these three different buckets.

Christine Bechtel – National Partnership for Women & Families – VP

Any more questions before we dive in?

M

A quick methodological question, identification of real patient outcomes, ADLs, IDLs, days missed work, is not dependent on identification of care processes. On the other hand, intermediate and other care process measures are guided by the processes that have been identified and prioritized. I just want to suggest that that different directionality probably confuses some of our discussion and we should at least try to pay attention to it or you may want to pay attention to it after this discussion.

Christine Bechtel – National Partnership for Women & Families – VP

That's a fair comment. Okay, I'm going to stop asking questions that I don't want to know the answer to and here we go. So this is the patient and family engagement Tiger Team members that David Lansky and I had the privilege of working with. It was a terrific group of people, including Paul, who I know is on the phone as well. We arrived ultimately at four sub-domains, broadly speaking, and you can see them listed here on your screen. We looked first at self-management and patient activation. That was sort of a lumped category, in our view. We also looked at honoring patient preferences and shared decision making and we've lumped these together. That may or may not be the right construct, we'd like your feedback on that. But the notion that you've got to understand patient preferences in broad ways, including communication preferences, advanced directives, but also then engage in shared decision making around treatment options. We viewed it as a ... process in that oftentimes shared decision making is more effective when it is built on activation and effective self-management as well.

So a third sub-domain that we talked about was patient health outcomes, which is measures that focus on really three different areas. One is disease and disability states, the second being health risk outcomes,

and the third being functional health status. And we recognize that these could be at the individual or at the population level. Then finally, and we were discussing this earlier, we identified the need to have some focus on coordination or connection to community resources as a measure concept. So in essence I'm going to talk to you about these.

But in the area of self-management and patient activation what we really focused on there were things looking at examples of the effective provision of personalized self-management resources and tools, and also the measurement of health risk behaviors as well as patient activation, and we had Judy Hibbard on the group I think who was very helpful in helping us think this through. We did originally talk about some specific measures, so things that we might look at in here around the patient activation measure or the cap surveys were examples just to lend some conceptual concreteness to these ideas. So patient preferences, ensure decision making, I talked a fair amount about that but these are the measure concepts that we would like to recommend that ONC have some measures developed in.

I think it's worth explaining a little bit more what we talked about with respect to the three patient health outcome measures. Disease and disability status we felt like could include two things. One was clinician provided diagnostic tests, so processes and some of the normal tests. We didn't really focus on that because we figured other groups would. These are normal processes of care. So where our recommendation in this area really focused on is patient self-reports of what their disease and disability status might be. So that's really focused on the individual level in that regard. We specifically believe that the measure concept should focus of course on how health IT can enable these measurements, particularly focused on high variation, high volume, and high cost conditions.

On health risk status, we focused on avoidable risk of death based on both biometric variables and on lifestyle variables and we talked about both the individual level and measures at the population level as well. Then finally in functional health status we talked a lot about, and I think, Jim, this gets to some of your comments about what are the outcomes that we're trying to achieve, but really what are patients able to achieve in their life. So some of the areas that we looked at were the Healthy Senior surveys, the How's Your Health? survey, and things like that, to look better at functional health status.

Community resources and coordination, which was our final sub-domain, was challenging because we felt it was important as a concept to include but had absolutely zero measures that we could really identify as potential examples out there. So this is an area that I think should be up for discussion by this group. I think it falls within or is similar to some of the discussion that we had earlier in the day around the importance of doing that. But is that a process, is that an outcome, how does that feed together, how does it fit with self-management and activation, for example? So this area was a little bit more challenging I think in that regard.

Let me stop and ask if David Lansky is on the phone, because he led a team of folks focused on methodological issues, particularly at looking at some of these measure concepts how we could do that with patient reported data, etc. David Lansky, are you on? He's not. Okay, so I will do my best.

We looked at two broad methodologic approaches here, and Josh, I think you were on these calls as well so you can chime in. One was sort of add-on and one was design-in. On the add-on piece we really focused mostly on surveys, things like a patient experience survey or How's your Health? survey. We recognized that the benefit of those is that they do begin to provide a feedback loop, and that feedback loop could occur either after care, as in a patient experience survey that retrospectively looks at how well does your provider communicate and how well were they coordinating your care, did you understand instructions, etc. But those same surveys could also be informing the point of care before even care happens, so a functional health status, for example, survey could inform treatment recommendations before the patient even gets into the office. We heard a great example from Jim Weinstein about that.

The second component that we talked about, and we didn't have time to talk as much about, although the group I think had a pretty clear preference for it, which is how you might design-in patient reported data

into the care process, into the process itself, care flow. We talked more about, in that example, how you could take patient reported data and really integrate it at all points in the care process in a way that allows the care process and experience to really be informed by that information.

We had lots of discussions about both of these methodologic issues. I think it's worth mentioning two things. One is getting some feedback in the RFI/RFP process around these concepts from a methodologic perspective, but I also think it's probably worth ONC considering some work to look at what's out there in terms of the design-in approach. We know that there are lots of health systems that have that kind of approach to things, Dartmouth, Geisinger, and others do, what's the experience out there and what does it take from an information technology perspective and then how can we measure that from a meaningful use construct.

That's that. Let me ask, I know Paul Wallace is on the line and Josh and others, if you want to chime in and supplement anything or correct anything that I've said.

Paul Wallace – Kaiser Permanente – Medical Director

I think you did a great job. I don't have anything to add.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is Paul Tang saying the same thing. I think part of the contribution is to try to move these measures and focus more on the patient's perspective, but also I thought it was very exciting for us to talk about and how could this contribute to care rather than everything being through the

M

I think one of the technical issues is really how the data got incorporated into the EHR for the purposes of meaningful use, and so that was also a part of the discussions as well, thinking about the specific processes by which data might be entered into the record. That could certainly be through patient portals, it could be through kiosks, it could be through other technologies such as IVR, interactive voice response, for people who might not be using computers. So there might be different methodologies to ensure that you don't introduce sampling bias and things like that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

A quick comment, one of the rate limiting steps in this in settings where it's being done is the difficulty of finding validated instruments that are maximally parsimonious.

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

I think that is a challenge in the next two years. I do believe it will be possible to have very powerful and parsimonious measures of functional health status building on the VR-12, VR-36, and the PROMUS based measures that NIH has funded that have short forms as well as longer. On risk, the avoidable risk of death work, it's based on the best epidemiologic data available that can be brought together and used for a one number avoidable risk of death of all causes for adults. So I think there's really good hope that within two years we could have parsimonious and valid and extremely useful and modifiable measures of functioning and health risk.

Paul Wallace – Kaiser Permanente – Medical Director

To build on that a little bit, and maybe it's stretching the definition of parsimonious, but I think one of the things that we're discovering is that parsimony has both technical aspects and social aspects, and the technical aspects include how data finds its way into the database. The social aspects include how we tap into a variety of different roles, particularly when they're quite different, like provider and patient, to capture similar things like functional status.

Christine Bechtel – National Partnership for Women & Families – VP

Other questions? Actually, I'm sorry. I actually have a few that I totally forgot about.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

What's interesting about this is are we meaning to do the measures on a census of patients, or at least an attempt to get to a census of patients because we expect the results to influence their care? Or, are we doing it on a sample of patients in order to understand better for the practice and ... understand better what the patient ... for example, what their practices are. In the latter case, and particularly with some of the experience that we had in New York City, was there was some measure of concern about having the information from the patient experience survey be identifiable for the providers. I don't know how much of a real concern this is or not, but that they may feel that their care may be adversely affected if they reported, if they complained about some aspects of their care. So that's something I'd love to hear both about in terms of what is the goal here for these. Is it the census or the sample and the identifiability issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Farzad, that's a great question. I think the excitement came for number one, which is to use this data for the census, meaning a patient at a time. Let's talk about the functional status, for example, and how what we do together influences the quality of life, the quality of their health, basically.

With respect to the second, we actually also had a very important discussion about how these experience of care patient satisfaction ratings typically have that nuance that you mentioned, which is people are afraid of what your doctor might think of you or even how they may treat you based on your responses to the patient satisfaction things. One of the observations we had is that most patients who return surveys, 90% of the responses are favorable and you can just say well, why is that? You can hypothesize as to why that might be. So we would argue against that of course being identifiable in terms of when it gets back to the doc.

But we had a corollary to that observation that says, and this is helpful to the people who conduct these surveys to divvy up all the bunched up 90% favorable ratings into percentiles and cause a massive difference in the percentiles based on a very small difference in the absolute rating. The consequence of that is a diversion of resources into chasing the difference between 90% and 92% favorable rating when we could be spending a lot more of our efforts improving the experience of care.

Christine Bechtel – National Partnership for Women & Families – VP

I'll just add to that by saying as well that I think one of the challenges that we face certainly has been the willingness of patients to identify their providers, but one of the issues that we've also talked about is how to make the data more actionable for providers and more beneficial to patients. So I think this is an area that ONC could really support some innovation around in asking the broader community, who has experience in these experience surveys, how to innovate and evolve them.

For example, how could we, or could we take the individual results of the patient experience survey and feed it back into a decision support tool that might alert the provider there is an opportunity here for better care coordination, there is an opportunity for a different kind of self-management resource based on what the feedback that I've given as a patient might be. So I think the link between experience and HIT was something that we for sure explored, but I'm not sure that we got to the bottom too and I think it would be a really valuable question for public input as well.

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

... Farzad's question, again. It's probably a role for both a census approach and a sample approach. Right now using the help of seniors that's a sampling approach and it would be perhaps relatively easy to build on that in the shorter term to add measure concepts to the health ... senior survey, which is being used to evaluate Medicare Advantage programs. But probably the future is better served by the design-in approach and there, if Jim Weinstein were on the phone he could explain how when he sees a patient over time with a back problem, he's an orthopedic surgeon, he's always looking at that patient's current functional status, that patient's current disability associated with the back using a particular scale, an

Oswestry index. He's looking at how much the prior treatments have helped that patient in ways that they hope to be helped, sleeping, going to work, freedom from pain.

That's moving over time, so when Jim sees the patient he knows about the impact of prior treatments on functioning, prior treatments on back disability, and prior treatments influence on perceived health benefit from the care that they've gotten. So that creates a very focused conversation about how that patient is doing and what could be done next in terms of a plan of care to get the best functioning and back specific results, and for that patient to get the health benefits that they had hoped, back to work, better able to sleep, etc.

Christine Bechtel – National Partnership for Women & Families – VP

Peter?

Peter Basch – MedStar Health – Medical Director

One comment and one question. In terms of the community resources I think that it's a terrific thing to think about but also to think about that one of the factors that probably in many cases leads to less use than we'd like to see is a lack of availability of community resources. So we need to think about staging that consideration ... as more aspirational for later years. But certainly as measures are put down there, as Farzad has reminded me, even if they are a bit of a stretch they can sometimes help to stimulate the market as well.

My question goes to self-management and activation. Have you guys thought about applicability of that to inpatient, outpatient environments and how applicable they are to different specialties, dermatology, let's say, versus family medicine?

Christine Bechtel – National Partnership for Women & Families – VP

We did not, but I think that's in the context of the RFI. Why are you pointing a watch at me, timeline? That's bad.

M

... his watch.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, so hopefully, Peter, that answers your question.

Peter Basch – MedStar Health – Medical Director

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

The last question is to Sarah.

Sarah Scholle – NCQA – Assistant Vice President, Research

I think what I saw in your measure concepts is a real division between items that are eliciting information from patients and families at the time of care who are influencing care, versus items like patient experience surveys, which I think have a major role in providing accountability and need that unbiased data collection process sampling that can be verified, lack of ability and trying to avoid practices' ability to influence their results. It's not just from patients being reluctant. It's from providers saying I really want a good score from this. So we need to be aware of the things.

Did you have a discussion about how much of this is information that a member of the health care team collects during the visit as part of the flow of the visit, as opposed to what the patient inputs before the visit? I'm trying to think about that process, if it's really going to be used during the visits to try to help decide what the care plan will be or if you really want to understand something about how patient

preferences are incorporated into a decision making process. Did you talk about whose responsibility is it to get that information?

Christine Bechtel – National Partnership for Women & Families – VP

I would say that it is different for every measure concept, because they, as you point out, are directionally different. But we did not get to a level of detail where we might say well, who is the nurse and how is this collected. We assume that what we're doing with staying at the conceptual level of what are the right questions to ask and then in through the RFI/RFP have a common process that we might get to parsimony and including people saying this is not a measure that we can collect. Does that make sense? Okay.

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

The issues are the future issues but just by way of example, the last two days we had a team of nine people from EPIC at Dartmouth and it was the team at EPIC that's working on My Chart and the patient reported information. The point was to improve EPIC's functionality, to gather patient reported data, patient reported information, in the context of the patient's care over time. It's that kind of improvements in HIT environments that vendors will make and that need to be made in order for the information to flow into the care giving context point of service and to make a difference. Vendors, some of them are moving very rapidly in this direction.

Christine Bechtel – National Partnership for Women & Families – VP

I don't want us to get the hook again, so we're going to go to the next presentation, which is the population and public health committee, Jesse Singer. Are you on the line?

Jesse Singer – DHMH of New York City – Exec. Dir. Development

I am.

Christine Bechtel – National Partnership for Women & Families – VP

Terrific. Take it away.

Jesse Singer – DHMH of New York City – Exec. Dir. Development

I'm Jesse Singer from the New York City Department of Health and Mental Hygiene. I do want to thank our Tiger Team. I was extremely privileged to work with them, an extremely passionate group. I would say passionate to say the least. Our calls were anything but unexciting. I also want to say at the outset that I could not see the Web presentation, of course an IT issue. So I'll try to call the slide numbers, but if I get out of alignment please let me know.

Slide two, you can see everyone on this team. Slide three, the four guiding principles that we went by, everyone's very familiar with this I'm sure. I won't go crazy on this slide. But I do want to talk about the second bullet, "Preventable Burden." This is really the unifying goal that we used, when you're talking about population health the world is your oyster and we needed a way to corral everyone, and so what we decided to do is say what's killing the most people and let's work on that. What are the risks that impact them? What's killing the most people and let's work on that. All of the measure domains, the sub-domains that I'm going to be talking about all stem from that. I believe you guys have a Word document also, and the references that we use are in there.

I also want to talk about the last bullet, "Enabling Longitudinal Measurements." I'm still on slide three. This is something really important to us. We wanted to be bold and we did want to be innovative and we really wanted to push the envelope on measure concept. So the team felt there were plenty of measures out there that say how many folks have hypertension and are controlled, or how many folks have diabetes and are controlled, but what we really wanted to do is say accentuate the delta concept of moving a patient through the continuum of unhealthy to healthy and we really wanted to overcome clinical inertia, really, on the part of providers that they may not even realize. So a lot of our measures focus on how

many of your patients were out of control that are now in control, that same patient, and I'll get more into that as we go.

Slide four, these are our three population and public health sub-domains. The first one was healthy lifestyle behaviors. These consist of smoking, obesity, and alcohol use all stemming from really the top risk factors that influence the top causes of death. The next was effective preventive services, the same type of thing, but these are less behavior modifiable and these are more procurement of care, so blood pressure, glucose control and depression were the three here.

Then our last sub-domain was what we call "Health Equity." This is probably the most difficult concept to come up with. The group felt extremely strongly about addressing disparities and we felt that this is a huge gap in current measurement and probably one of the number one indicators of how a patient's going to do in the health care system if they can even access care. So we played with the idea of addressing disparities within each of the other sub-domains but we thought due to such a severe impact on patient health we thought it deserved its own sub-domain. I think we came up with some pretty good thoughts around this measure concept.

Slide five, "Recommendations," so healthy lifestyle behaviors, as I mentioned, smoking. Most of our measures focus on the delta concept and the longitudinal concept, so an example for smoking cessation would be patients who identified at the beginning of the period in question as being current smokers. How many of those at the end of the period in question identified as former smokers? We applied the same idea, to use body mass index, obesity, which everyone knows has a huge impact on causes of death. And so what we tried to do here was to say an example measure might be for all patients who at the beginning of the period identified as obese by their BMI, how many at the end of the period identified as either overweight, normal weight, or had a significant percent of weight loss?

So we really focused on pushing patients and really having providers think about overcoming their clinical inertia and moving patients through the continuum of care instead of just counting how many of their patients are controlled, how many are uncontrolled. We really wanted to track how many are you moving. The last piece, this is not a delta measure, but the group felt equally strong about this, alcohol use also has a huge impact on causes of death and this is just putting it out there that we want to make sure that folks get screened.

Slide six, "Effective Preventive Services," the same template really as the previous slide; blood pressure, tracking change over time, tracking the delta of this patient over time. So an example here might be the patients at the beginning of the period who were JNC 7, classification of stage two, how many at the end of the period now were at stage one or were in complete control. The same thing for glucose monitoring, how many were greater than 9% at the beginning who are now less than 9%. So this is really our overarching theme. Mental health, again, equivalent to the alcohol screening, equally important in terms of depression or other mental health issues and their impact on morbidity and mortality.

Slide seven, "Health Equity." This is our most difficult concept to get our heads around and really how to work in all aspects of disparities, social determinants, environmental factors, and we thought it did deserve its own sub-domain. So the concept here is we looked at the AHRQ disparities report and we looked at their priority population and so what we decided was that really every measure should have a paired measure of disparity. So for all the measures in the PBS-2 sub-domains, they should also be cut by these disparities, the idea being using these priority populations, things like race, ethnicity, recent immigrant status, limited English proficiency status, low income, women, children, etc., for the measures in the other two sub-domains. Really it can be any measures, but this is applicable too. We said that there should be no discrepancy when comparing rates of these measures among those within these priority populations and those not included in these populations.

So an example, this is kind of a measure of measures, and so I think a good example of this would be for each clinical measure, so for smoking, blood pressure, obesity, there should be a paired measure with it,

an additional measure where the calculation would be something like the percent of priority populations where there was no discrepancy in this measure. We thought, as everyone knows, disparities are probably the number one determinant of health in the country, so we thought there was a huge gap here and we thought this would be a way to bring it very much to the forefront. That's it.

Christine Bechtel – National Partnership for Women & Families – VP

Thank you so much, Jesse. That was terrific. So questions for Jesse?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I found this presentation very interesting and I wanted to just check my understanding of an underlying theme throughout the concept. It's sort of like Farzad's question, is it census or individual care? It almost seems like you brought public health population measures down to the individual level because what you're doing is you're tracking longitudinal care for individuals and I think that's a good thing, but am I correct in my interpretation of the measure concepts you're proposing?

Jesse Singer – DHMH of New York City – Exec. Dir. Development

One hundred percent, absolutely. The idea, like what we've done in New York we try to do that. It's a pretty powerful tool for providers to have when they're seeing patients. So at the point of care if they know, they think, honestly docs all think that they're doing a great job and they all intend to do a great job, and they don't even know the data. So it's easy when you see a patient and they leave satisfied with their visit, but it's another thing when you say how many of your patients have you gotten from obese to overweight in the past year. They think they might have done a good job but having that data on a patient to patient level I think is really the powerful piece of this, because when you're looking at it on a population based level, while it is powerful for the docs and we do present that to them, the day-to-day, the in and out of seeing patient after patient, they need to see this data. They know their patients. Their patients have faces and personalities, unlike the population data, but I think the idea behind this is exactly what you said, bringing the population view down to the day-to-day point of care individual patient level.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's very exciting and it's a lot like the discussion we had with the population level assessment of patient engagement, we really want to bring it day-to-day. The other thing is this adds to the importance of our bidirectional public health kind of exchange.

Jesse Singer – DHMH of New York City – Exec. Dir. Development

Absolutely.

Christine Bechtel – National Partnership for Women & Families – VP

So I have John and then Bob.

Jon White – AHRQ/HHS – Director IT

Thank you for the presentation. It was excellent. I have a couple of questions on it for you. I loved the focus on disparities, ..., that was good. Keep it up. What I heard you suggest with the paired measures was it sounded like you were talking about an index measure looking across populations with disparities as opposed to specific priority populations and a measure for each one of those. Did I misinterpret that?

Jesse Singer – DHMH of New York City – Exec. Dir. Development

Yes, the measure we came up with, we tried to think, we've gone through that iteration and we said there were eight priority populations and we wanted to add a couple more, education and insurance status. But we were given a very clear limitation on the number of measures that we wanted to produce that we could produce, so we said if we cut each measure by every single group we'd be looking at about ten measures per measure, three measures in each sub-domain, so we'd be looking at over 90 measures. So we didn't think that was feasible and we wanted to make sure that we weren't dismissed out of hand for our exuberance. So we decided to make an aggregate of disparity measures, and so the provider would be measured on basically the measure would come out as, the numerator would be the number of priority

populations where no discrepancy exists for each measure, and the denominator would be those priority populations that were applicable. I do agree it would definitely be great to see it on an individual basis, but if you multiply this by all of the measures out there it just becomes very impractical.

Jon White – AHRQ/HHS – Director IT

Okay. That's helpful. That will be a fascinating topic to discuss as we move forward. The second, less question more an observation, in your first two groups of slides both of them referred to measure, for example, screening of alcohol abuse, using a validated tool. I just wanted to throw out the concept that yes, you should use validated tools. Just because something is validated on a sheet of paper does not automatically translate over well if you plan to gather that information using a health IT system. It may translate well, but just as you think about validated tools and what that means ..., so thanks.

Bob Kocher – McKinsey & Company – Associate Principal

You guys did a great job. A couple of observations, the indexation, the concept I think really fits the parsimony theme well and then the one ... I think will make this very, very powerful for practices. What also strikes me is by doing this we demonstrate the utility of the doctors of EHRs because at the point of care with the patient in front of you it helps you think about population health and public health in ways that you wouldn't naturally do it. This is a really nice way to go back to, Peter, your point about behavior change ... illustrating that. Also, ... by getting doctors to focus on these things which they wouldn't we have a lot of potential future value that will come. Then this really reinforces the patient ... engagement team, in that the notion that you had about getting patient satisfaction and patient's preferences built in earlier into the interaction really ties this all together well with the notion about preventive services and lifestyle behaviors, how you would intervene. So I think there's a lot of synergy between those groups in the way that these are designed, which probably we need to protect as we iterate the portfolio. Good job, Jesse.

Christine Bechtel – National Partnership for Women & Families – VP

Peter and then Helen.

Peter Basch – MedStar Health – Medical Director

I'll echo, great job. This is terrific. The same question I asked of the other Tiger Team, which is have you thought about domain applicability to your three sub-domains, healthy lifestyle; preventive service reducing disease burden; and health equity inpatient and outpatient, specialty focus and so forth?

Jesse Singer – DHMH of New York City – Exec. Dir. Development

We did talk about that. Given the short amount of time to produce it, I think we had an eye towards the ambulatory setting, but I think one of the other measures that I didn't mention that we thought of was moving patients from uninsured to insured status. And we thought that especially the health equity measures worked well on both inpatient and outpatient. The others, really ending up in a hospital for these other conditions means something failed in the outpatient, and so not to get into the other concepts, but I think definitely for our health equity measures, I think they worked very well, both inpatient and outpatient. We definitely consider it.

Christine Bechtel – National Partnership for Women & Families – VP

The last question to Helen. Oh, Karen, sorry, because I know I didn't get you last time.

Helen Burstin – NQF – Senior VP, Performance Measures

Great presentation. I just had a question about the disparities lens. It just may be the way it's being presented. I guess as somebody who did the first disparities report I'm just a little uncomfortable about the idea that these are separate measures. To me there's something really important about the idea that it is a measure stratified by the populations at most risk. So the idea of creating additional measures, or at least the implication, was something that just made me a bit anxious. I like the overall idea of thinking about how you might use measures like this for accountability versus QI. I think for accountability some index that looks at how well you're doing for vulnerable populations has a great deal of appeal. But I do

think, particularly the whole point of measuring is to improve and if you don't have the level of specificity of stratification by each year populations at risk you can't target populations for improvement. So I just think because we're not all about public reporting, a funny thing coming from me, but there really are critical ways to use these measures and I wouldn't want it to roll up so high that the roll down doesn't become a powerful force for improvement.

Jesse Singer – DHMH of New York City – Exec. Dir. Development

I couldn't agree more. We spent many hours on this topic and I do agree and I think there's more due to the practical confines of this exercise that we chose to aggregate. I think there's definite advantages of having the aggregate view and I think allowing the physicians to drill down to the priority population view as well as the aggregate view, I think is really powerful. I think if the doc sees only 30% of the time am I eliminating disparities in my population, that's important. Then they can look at that and maybe they can drill down on that and say, and here's where I'm suffering the most, it's women, children, and recent immigrants. I agree with you. I think we definitely have to have population by population, but I think it's important to also have the roll up in terms of overall population management and then allow the docs to drill down later.

Christine Bechtel – National Partnership for Women & Families – VP

Karen?

Karen Kmetik, AMA

Very similar, just to add that when I just looked at your statement on health equity, to me you stated the goal. The whole reason we're doing all of this is so that we eliminate disparities. That's a nice way, in my mind, to say that that's the goal. I was just thinking from where we are today, and I know that we're looking at aspirational, but still from where we are today of meaningful use stage one, 50% of your patients have the data, to this goal, which is great, this is where we want to get to, is there not something in between that we could put forward to move everyone toward this goal? And maybe it's around what Helen was saying about the stratification, but I was wondering if you had any discussion of something in between today and this goal?

Jesse Singer – DHMH of New York City – Exec. Dir. Development

To tell the truth we didn't. I think we felt so strongly, part of our discussions involve, we did have the discussions around saying is this achievable? Is this something that providers are ready for? Is this something that health IT is ready for? I think due to the absence of such disparity measures at all we just went for it. We kind of reached for the stars and we said this is the long term goal, we point folks here, and we'll let the measure developers work on it. We put forth some example measures, but I feel like we can do some interim stuff. I would love to break down, believe me, no one wants to break down the disparities into the individual priority populations more than I. It was more of what is it that we want to achieve? We thought this could iterate down. We thought what we proposed was reaching for the stars and eventually maybe we'd get something in the upper atmosphere at the most, and so we just decided to go forward. And I think I'd love to be part of any discussion on interim measures and interim goals and how we can get there as a stepping stone to this ultimate goal.

Christine Bechtel – National Partnership for Women & Families – VP

Great. Thank you so much, Jesse. Terrific job. So we're going to jump into— Yes?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Just quickly a comment. Jesse, I wanted to understand, Jim Walker, under resourced populations are not uni-dimensional. Some patients are highly resourced in some ways and profoundly unresourced in other ways, and they obviously occupy spaces along a spectrum of resource access and availability. It seems to me that that would strengthen the argument for having a common set of measures that we use for all patients, including the ones we haven't identified yet how they're under resourced. Is that what you were saying?

Jesse Singer – DHMH of New York City – Exec. Dir. Development

We considered social determinants, environmental factors, a lot of folks brought up, especially from IHS, our patients live in rural locations and they don't even have adequate roads, forget about social workers, care managers and things. So this really came about as just a way to combine all of that, and it combined it in an elegant way and I just think you can cut this many different ways, and I think hitting on the lack of resources that may occur in different communities, we were trying to think nationally and how best to scale a disparities measure so that it was as parsimonious as possible. Unfortunately, it's parsimony amongst disparate populations, but that was our thought process on that. I'm not sure if that answers what you're asking.

Christine Bechtel – National Partnership for Women & Families – VP

Thank you again, Jesse. We're going to jump into the Patient Safety Tiger Team. Do we have Neil Calman on the line? I know, Tripp, you were prepared to pinch hit if necessary.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Neil, I hope you're here.

Christine Bechtel – National Partnership for Women & Families – VP

He's not, okay. So Dr. Tripp Bradd has been kind enough to pinch hit.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

I will say I learned a long time ago you show up to all the meetings so you can't be volunteered, and that ended up being my undoing. Now I've been asked to present off a set of slides I didn't see until this morning. But anyway, I'll try my best. I want to thank Neil especially because he helped organize this, and again also Leah Marcotte from ONC. She was very helpful in her processes and she's over here to my right to pinch me if I get off topic and to help me out too. I also would ask Peter Basch and Jacob Reider, who are also here thankfully, to be the wind under my wings, so to speak, and anyone else who chimes in later, I appreciate it.

This is our group. We were fairly spirited. We met three times. My job will be storyteller today and we'll try and review everything. The four guiding principles of our team were exactly as listed here: to maximize impact across both hospitals and ambulatory care settings; to be HIT sensitive, which I think some of our things are particularly helpful for; to be frugal, which is a word I like better than parsimonious because it's less letters and would save a lot of money; and anyway the focus on reporting is also important so we'll talk about that.

These are the four safety sub-domains that over three meetings we came to, just expanded and contracted, split and lumped over a period of meetings, and I would ask Peter and Jacob to chime in as we hit each one of these as needed. The medication safety was the big one. Certainly it's one of the easier ones to measure. We had some great ideas about adverse drug events and how they're under reported. We'll talk about that. The hospital associated events, and this is more of a lumpier thing, as far as the hospital associated infections, venous thrombo, embolism prophylaxis, and of course falls, which actually crossed into the ambulatory realm also.

Patient identification, although we were in midstream that was brought up, and I think it's a very important thing because many of the errors that occur in care happen to be with misidentification. Then Jacob brought up a good one towards the end about EHR errors and the concepts revolving around this.

Medication safety speaks for itself. We had a great idea, and I think whether it's an easy button on the EHR that says "Report it to the FDA Adverse Event Recording System" we recognize that it is probably very under reported across all realms. And if we could do that we could actually accumulate data to actually pick up problems and we called it Clinical Phase V trials, I think it would really work. The other thing of course was to measure medications. Of course this more goes to what a lot of EHRs are based around, that is clinical decision reports and CPOE. Interestingly, however, and I think it's important to

bring this point up, is about the use of inappropriate drugs in the elderly NQF measure, one that I think any primary care physician would really stand behind in terms of preventing many problems and how we could measure those.

Peter Basch – MedStar Health – Medical Director

I'd just like to jump in on this one. The other thing we talked about was thinking, and one of them goes to your goal point, if you can go back a slide, the second major bullet point was how to think about this for stage two and not just aspirationally was we have now a measure about enabling drug-drug-drug allergy interactions in EHR and thinking about we don't really have anything specified yet about the need to use it. So conceptually we want to think about moving people toward not doing what many do now, which is oh yes, there's a red stop sign in my EHR, to we need to start thinking about how to get people to pay attention to what that means. Obviously there's a lot of work surrounding that in terms of being over alerted and so forth.

The other thing that came up in this area that we thought was relatively low hanging fruit was looking at, and there could be one for inpatient ..., certainly for the outpatient world we thought of high risk medication in an ambulatory setting being warfarin, and think about some easy things to do with warfarin monitoring that would fall in the realm of process measure, such as, one, having an indication target range and a stop date for warfarin. Things that are intermediately needed to start looking at do you have some in range or do you have them on medication for life when it should have been six months and so forth.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Yes, and using lab in general to help use these data points across all drugs, whatever they are. Jacob, anything you want to add?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I think this actually goes to the EHR use too because one of the things we talked about was click fatigue, people click right through some of these things and that is a problem we see.

Peter Basch – MedStar Health – Medical Director

Hey, Tripp you asked my opinion here, so I'll just throw in the second bullet here, we talked about maybe a measure of whether adverse event reports were submitted or not. So we know that docs don't submit adverse event reports, could EHRs facilitate that and could we then measure it?

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

I'm actually hoping their discussion will preempt any questions, actually. Hospital associated events, obviously there are lots of things that we talked about. I think some of the things we talked about with hospital associated infections revolved around foreign bodies in the body, that is catheters of different sorts, be they central lines or endotracheal tubes or Foley catheters. Obviously these are things that can be measured. The measures for VTE particularly revolved around trying to capture people who needed it, as opposed to actually using it correctly. Of course those things are important.

The last one that I think Peter can actually comment on is falls events and screening. Certainly the nursing homes have been doing this for a long time, hospitals are into it, but I think if the patients don't fall at home as regard to the screening they won't show up in the hospital. So how we can measure and do those things? Actually Peter gave us a good example of that. Peter, do you have anything to say about that?

Peter Basch – MedStar Health – Medical Director

The only comment I'd make, and I think that one is also relatively low hanging fruit, so the PQR measure already and a lot of people are routinely beginning to pull in fall screening data. If there is one or more falls with injury, or two or more falls during a year, bring up secondary prompt, so that falls prevention

strategy. I think this is something that is doable and is something that we can think about introducing in the near term and in an iterative fashion, but in the inpatient and outpatient environment.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

Exactly. In fact, falls are usually a symptom of something else. Let's move on to – any comments? Anyway, patient identification, we recognize that there are lots of times in using the EHR is mentioning, clicking through clinical decision support, things like that, really came up quite a bit. But the one thing that we recognize is sometimes, whether at the bedside as a nurse is giving him medication, or even in an outpatient setting when a phone call is taken and recorded in the wrong patient's chart, there needs to be a good way of identifying patients on the front end. We talked a little bit about pictures, is a good example. I don't think we'll get to retinal scans, but things that would help the process of identifying patients correctly would be a very good safety feature.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

If I could add to that since I had proposed putting this one in here, we certainly have a world of literature on incorrect patient identification in the hospital world, wrong surgery, wrong patient, and I think most of us know those studies. But we only have anecdotal information about what happens probably 100 times more commonly in the outpatient world, where a patient is called back from reception or waiting area with a first name because somebody can't pronounce their last name, and it's muffled and four people stand up with the same first name and one of them chooses to go forward. The provider's never seen that patient before, conducts a visit, and thinks maybe at the end of the day or that night during dinner, was that the right John Smith or not? I think that this happens a lot and we're not really beginning to think about ways in the outpatient world to embed positive patient ID in our workflow.

Peter Basch – MedStar Health – Medical Director

These things actually end up cut across all the other safety measures in one way or the other sometimes.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

EHR errors, I think Jacob can get credit for this, in the sense that there are a lot of things that happen in the care of the patients that might best be addressed. For instance, reports that somehow show up in the chart that never get acted upon, if you will, administrative malpractice. We talked about time, length of addressing reports that come back both to review and both to let the patients be engaged with, mentioning two to three business days. We also talked about results that were ordered that weren't done, that is, closing the loop with order entry. So there are some of the errors that can occur, I think, Jacob, you have some other ideas also.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I think in general you think about there are frequently reports of perceived or real patient safety concerns that arise from the use of EHRs, so the vendor community is very interested in not putting our heads in the sand and learning about these, and so in the same way that there are adverse event reports in the pharmaceutical industry, we think that finding a way as an industry to collaborate here and measure adverse event reports would be a very positive thing.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

Let me circle back to one, and this goes back to the public comments, and Thomas would want me to say this, is that there was a person representing a nursing organization that mentioned pressure ulcers as a safety issue, and I guess I need to mention that just in the public way. Did we cover everything guys?

M

Yes.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

Thank you very much.

Christine Bechtel – National Partnership for Women & Families – VP

Peter, you cannot possibly have any questions. Does anybody else have questions? Eva, who is changing her identity. You were Carolyn earlier and now you're Cary. That's good. But this is Eva Powell from the National Partnership.

Eva Powell – National Partnership for Women & Families – Director IT

Thank you for the presentation. I think it's well done and well covered. The one thing, and I would also comment on the last bullet point about EHR safety, I think that's an important area to investigate because there's not a lot known about that. The one thing that's concerning to me is that consumers and patients are not represented here and I think when we think about safety largely the thought is that this is a very provider controlled thing. This is a provider issue to deal with. There's some truth to that, but I think what's important, and this goes to the point about using the data we have available, and are we using the data that we have available, and one of the most underused sources of data of course is the patient and family. There is no one who knows the patient better than the family member and so it worries me if we move forward with this without somehow reflecting in the measure concept.

I don't think you have to change the ones you have here. I think that it could be worked into what you have already, the concept that if we're not listening to patients and their families then we cannot have a safe practice environment. One example would be in medication safety, which is a category you already have, are patients providing input into adverse drug events? Perhaps that's something you need to discuss and that will be included at the measure level. But I think it's important to be very explicit about that and the concept.

I had a conversation yesterday with executive director of the consumers advancing patient safety and they are working on a database themselves on this. So this is not an area that's way in the future, I don't think. I think there are opportunities to act on this in the near term. Then also in the hospital associated events probably many of you, if not everyone, is aware of the story of Jesse Keen, who's an 18-month-old child who died at one of the premier institutions, Hopkins, of dehydration because the multiple pleas of her mother to address her seeking liquids were ignored by staff. So I just think that this is an area that patients and their families have a critical role. Rapid response team, there's a lot of work being done in the area of rapid response teams, and they are gathering data. So again this is not an area that's way out in the future, this is an area where there's work already being done, where there's probably a lot to build on in terms of measurement in the near term.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

... one of the things we talked about in our group on the medication safety was consideration of incorporating yet another question, which some people do on a regular basis and some people never do, which is not just how you're feeling today, but are you having problems with any of your medications. That's something that could be a standard question, it could be standardized in terms of its answers and then if yes then you can go down the med list and which ones and what are you experiencing and then we can have the easy button for, I don't know if it's correlated, but this was a reported possible issue.

Christine Bechtel – National Partnership for Women & Families – VP

Karen?

Karen Kmetick, AMA

I was wondering if medication adherence belongs somewhere here, or was that covered by another Tiger Team? I'm thinking, Jacob, from an EHR vendor solution, even beginning with dispense information.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

We did and we struggle a lot with safety versus quality. As I'm thinking now as you ask, there are sometimes when non-adherence could be unsafe, a lot of times where non-adherence could result in poor quality such as measures getting out of control. So I think we were stuck in that conversation at our

first conference call and we decided let's let that one go because it may fit more under quality, although thank you for raising it.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

I think it was also brought up about reconciling the list with the patient. That's the best way to find out if they're adhering.

Christine Bechtel – National Partnership for Women & Families – VP

Jim, did you have a question?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

No. We bounced stuff against this before and I think your points are well taken. If we were thoughtful about the health care team and said what we're talking about is the patient and the patient's caregivers and doctors and nurses and case managers and transport people and long term post acute care and the whole set of people that need to work well together for the patient to receive seamless, satisfactory, really high quality care, there's a whole lot of unclarity about our thinking that we wouldn't have to keep addressing in bits and pieces. Community resources sounds as if—they're not part of the health care team you know from our earlier discussions, so I think ... at some point, probably soon, to define the health care team and then our discussions could identify which particular elements of the team are appropriate for which particular activities, rather than acting as if we don't know what the team is.

Christine Bechtel – National Partnership for Women & Families – VP

Any last questions? I have Paul and then David, I hear you. So, Paul Wallace.

Paul Wallace – Kaiser Permanente – Medical Director

I just wanted to comment on the intersection between this work and patient and family involvement. Because I think that when we, even just using for instance anticoagulation therapy, there's no 100% safe way to administer anticoagulants but there are ways to manage risk optimally and managing risk optimally has to take into account the patient capabilities, preference, and values. So I think that if we really want to move these measures forward we'll also think about how do we ensure that when we're looking at actual occurrence rates and things like that, that we've taken into account the degree to which patients were involved in making the decision that underlies the use of the agent.

Christine Bechtel – National Partnership for Women & Families – VP

David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

Sorry to be in and out this morning. I appreciate the testimony and presentations. I'm wondering, echoing Eva's comments, whether it needs or doesn't need to be broken out separately, the patient reported adverse event outcome category. I know David Gates has done some good work on patient reported medication errors, information available from the patient in their home post discharge or post visit on side effects and complications associated with meds, that stream of event reporting, and it could apply obviously to adherence areas, other areas, whether we should just bundle that into the same measure concepts as the ones you've articulated, or pull out a separate set or parallel set of measure concepts which really emphasize the patient contribution to data. I don't know how to handle that in this next round of our work, but maybe the committee has some thoughts about whether that's embedded within these concepts or separate.

Christine Bechtel – National Partnership for Women & Families – VP

I think that's a good question, David.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I wonder if one way to do that is so the workgroup called for this one button submission to FDA that's in the provider report, if we could have a similar kind of way that it's easy for the patient to submit it via PHR

that would help. Also in the study that I think David is referring to from partners, they had as much as one-third of the medication administration prescriptions in the outpatient setting had some kind of side effect or adverse effect. So there's a lot of under reporting, not surprisingly, in the patient world as well. But some of that information, like in a previous discussion, could come directly back. So there's this cumulative population level assessment but there's also feedback back to the persons prescribing the medication. ... it's an important concept not to get lost.

Christine Bechtel – National Partnership for Women & Families – VP

Peter?

Peter Basch – MedStar Health – Medical Director

One final concept in this, these are great points on David and Paul, thinking about the whole medication ecosystem. Teeing off something that Jacob just said, that a key thing that we can use to look at a whole bunch of other things are med rec when a patient comes for a visit. If a patient isn't taking what we think we're taking sometimes there are reasons, due to cost, sometimes it's because they saw another physician who stopped something, started something else. Sometimes it's because of side effects. Sometimes, as I'm finding increasingly, it's because in our electronic medication history world we don't have clear stop dates or don't use this one, use that one. The patients who have been on multiple doses of medications have the most recent ones prescribed by, let's say, me or colleague and have something filled by a pharmacy that might be three steps away.

So we could learn a lot about paying attention to that process and thinking about it as a learning experience rather than just something to get over a check list and say yes, I did it, but I'm not thinking about why people aren't taking what they're taking, because that I think is the most important step.

M

A quick address to David's larger question. I would embed it, David. All the way across all these domains we have data that shows that patients can enter information as or more accurately than clinicians.

Christine Bechtel – National Partnership for Women & Families – VP

So we're going to jump into the efficiency environment. A flag for folks that were significantly over time, and this is a great and robust discussion, we had reserved some broader discussion time at the end for the group to talk across the domains and I think what we'll do is we'll end up eating into that a little bit. So let me suggest two things.

One is that the Tiger Teams that have still to present try to do their actual presentation in five minutes or less. We can re-decide, we probably don't need the principles, but to really focus in on the measure concept and then give people a chance to have a good and rich discussion in the Q&A, because I think that there's a lot of really meaty points coming out of our discussion in that regard. Then what we will do is use the more limited time at the end to just focus in on cross-cutting issues that we're seeing, as opposed to going back to individual groups. So does that sound good to everybody, or does anybody have a better alternative?

Okay, great, so we're going to try to do everybody in a pretty quick period of time, starting most appropriately with our Efficiency Tiger Team, Bob Kocher.

Bob Kocher – McKinsey & Company – Associate Principal

Good afternoon. We will model efficiency then in our comments. We're going ... parsimony Our team is a terrific group. One thing I'll say, though, in color is that we thought about listing degrees, but then we stopped because there were too many. So we were efficient in that regard too. Charles Kennedy was my coach here, Richard Bankowitz, Niall Brennan, Kate Goodrich, Robert Greene and Karen led the spirited, lengthy, involved discussions in an e-mail. So thank you to the team.

Now I'll be efficient. We accepted all the earlier principles. We used longer words here, so I won't go through them. But we also focused on impact, ... efficiency measures that were proxies for broader sets of action, spending, populations. We wanted measures that would actually benefit as many people as possible. We also tried to be very practical and so we bucketed our ideas into things you can do now and then things that you need R&D and future space to achieve. So hopefully in the creation of the RFI/RFP it will be simple to incorporate many of these concepts.

We came up with six sub-domains that we think are really important. I'll give you a bit of color on them, but I won't dig into all the details in the interest of efficiency. But the first one's around facilities. This is really about using the right frequency of facilities, the right locations of facilities, the right acuity of facilities, and then looking at reliability of the facilities.

The second one is on diagnostic testing, an area that has gotten a lot of attention for possibly overuse, underuse or misuse, so ... appropriateness in that area. Chronic diseases, and chronic disease patients with multiple sites and providers looking at how we can look at coordination across the care continuum was something that we felt was really, really important. Next is on medications and ...Karen, we had the discussions and Karen was a focal point for some of this, around adherence. So we think that working at usage and adherence and then appropriateness of medications, there are some very high opportunity targeted areas where you can look at this and it will give you a good sense of how it's working more broadly.

Efficient use of treatments, and this is really outside of medications and testing but more around systems and testing and care, that we have sense of how is an inpatient, outpatient organization actually performing against an alpha target, and what kind of rework are we seeing in the systems itself to look at reliability and resiliency.

Then the last one, and these overlap some with some of the earlier teams that maybe highlights the emerging consensus probably across all the teams of importance here, around preventing complications, averting disease, and looking at population health. I think that there's a lot of symmetry in the measures that we came forward with relative to the other teams.

Just a couple of concepts that I'll point out is that we think it's really important to, if you think about the location of care for chronic diseases, to think about the cost and quality of each level, looking for defects in care and working for omissions or lack of follow up. And this is an adherence beyond medications that we felt was very important to weave in that EHRs will allow you to get more color on in a much more timely and accurate way than we can today. We thought there was a lot of value in also looking at treatment plans and how they're actually implemented across provider locations and types and teams, and so again looking at ... making sure that actually the team itself is all delivering a good shared plan.

The last thing that I'll say, coming back to some of the stuff that Jesse brought up, we felt that it was really essential too that there was, as part of the cost of efficiency looking at prevention and wellness, that that's not purely populational but that's also very much a signature of what is an efficient and productive care system. So that's the flavor of the discussions. I'm going to stop because you wanted five minutes and questions. We have lots of detail in small font that those of you can read later.

Christine Bechtel – National Partnership for Women & Families – VP

Questions for Bob and our efficiency group, who was very efficient, thank you so much. Why don't we actually back up one slide just so that people can see while we're talking to your blue slide with the measures. Eva?

Eva Powell – National Partnership for Women & Families – Director IT

I guess this is more a comment than a question, but as a consumer advocate who believes strongly in the need for greater efficiency, I struggle with how to discuss this in the consumer community, but more so just the broader public. I think most consumer advocates understand the need for these efficiencies, and I'm wondering, again, it gets back to my earlier point about where there's the consumer in this, and are we using the data that we have well. Since there is evidence out there that shows that consumers or patients when they're presented with full and unbiased information about all treatment options generally pick the less invasive option, which usually then is also less expensive, I wonder if there's a way to make that linkage here with, again, patient engagement, shared decision making, those kinds of principles. Again, maybe that's something that's done at the measure level, but I worry when the consumer and patient are not explicitly in the concept that at the measure level that might get lost.

Bob Kocher – McKinsey & Company – Associate Principal

In our discussions that was very much a vein that we went down. I think our group had a lot of support for the shared decision making concepts regarding corporate in a previous one that I didn't highlight here. The other point I make is that we spent a lot of time thinking about overuse, underuse and duplicativeness, and making sure that there's ways in which we can better understand each of the benefits patients and consumers, by virtue of less exposure to adverse events, complications, and cost and that if we had a system that was focusing in these domains we believe it would be a lot more reliable, a lot more resilient, and probably lower cost.

Christine Bechtel – National Partnership for Women & Families – VP

In the queue, I have Jim, Farzad and Tripp. Jim?

M

You're permanently having questions.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Actually, I did, and it goes back to Eva's point, did you ever talk about open access to the office as an efficient way of taking care of the patient, you know, do the work today as opposed to putting it off? I know it's never happened in this room where you call your doctor and you have to wait weeks for an appointment. Was that discussed at all?

Bob Kocher – McKinsey & Company – Associate Principal

It was dreamt about by the team. We didn't discuss it in a specific sense of a measure. That said, the concept of easy access, more retail-like health hours, more responsiveness and more modalities through which you can reach your care team is one that I suspect that many in our group would have actually supported. And perhaps that's a corporate move up to public comments and ... to capture that and measure that.

Christine Bechtel – National Partnership for Women & Families – VP

Jim?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Just real quick, that's why case management works so well is because you have someone who's available to the patient who can help the patient either with anxiety or with starting in their emergency care plan or whatever and help them stay well out of the ED.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

One general topic I'm sure you guys discussed was whether the availability of information from EHRs versus from claims data, and in this case the claims and cost data, may be better and the data may be more difficult, some of this data that you're talking about, readmissions, let's say, for example, you may need to think about it differently if you're talking about information from clinical systems. So in other words, on the readmissions example you may need to have data collection in the EHR on a given

admission that asks was this person admitted in the past, discharged from this or another hospital in the past 30 days, as an example, which is somewhat of a different concept and whether there's any discussion about whether there's any advantage to doing those kinds of questions versus just simply using the claims data, that's one.

Then my second question was, coming back to what Karen said around medication adherence, it seems like you actually do have, at least in the measure concept here and specific examples, which I like very much, and the linkage between looking at medication adherence, particularly for those things on the population health priority list like antihypertensives, statins for cardiovascular, beta blockers, diabetes and so forth. So I think that's something that should definitely be acknowledged and highlighted.

Bob Kocher – McKinsey & Company – Associate Principal

On the claims versus EHR we spent a lot of time thinking through what's the best capture in claims, what's the best capture in EHRs. And ... both because on readmissions both are necessary because it's possible to put up providers that are far enough afield that you wouldn't necessarily know when you're in your EHR, usually, that there was other activity happening. So we think many of these could be done in the short term from claims augmented by EHRs and some need to have both in place to really get an absolutely concrete picture. But practically it also adds some quality control ... having multiple ways to actually get to the answers. So we think that there are some benefits to using both and now I've caused many ... to go up.

Christine Bechtel – National Partnership for Women & Families – VP

I have Jon, Tom, Daniel, and Karen, and we need to have time for phone folks, and Jim McAndrews you're still up.

Jon White – AHRQ/HHS – Director IT

I'll be quick. I really like the idea of access as a measure of efficiency. I'd push us to think about how that's HIT sensitive, so maybe instead of I've got an open schedule maybe I go the Kaiser way and use messaging with my patients to be able to make more efficient use of their time and my time, that sort of a thing.

Christine Bechtel – National Partnership for Women & Families – VP

Tom?

Tom Sang – ONC

This is going back to Farzad's points about using multiple data sources, both claims and clinical. And ... on the readmissions issue you're going to need clinical data points on the relatedness associated with the first admission, so in terms of clinical data, like for example for CHF, if the second readmission is showing shortness of breath or dyspnea on exertion or whatever, that clinical data element will be from HIT EHR as opposed to claims data.

Christine Bechtel – National Partnership for Women & Families – VP

Daniel?

Daniel Green – CMS/HHS – Medical Director

Hi. Since I haven't said anything ... I'll continue to say nothing. Thanks for letting me be a part of the group. I just real quick wanted to follow up with what Farzad and Bob were saying about whether you should use claims or the need to use claims and HIT in terms of trying to figure out some of these was the patient hospitalized before or have they had redundant lab testing or CTs or what have you. I think as the NHIN and the interoperability in general are more widely used and adopted I think that issue will go away. I don't think we'll need to use claims quite as much because we'll be able to communicate with one another to find out, okay the patient was in Seattle this weekend visiting their sister, and oh, by the way, they had a visit to the ER for abdominal pain and yes, they had a CT so we don't need to repeat it when they come back to D.C.

Christine Bechtel – National Partnership for Women & Families – VP

Good point. Great point. Karen?

Karen Kmetick, AMA

Just two quick things. One, to follow up on the discussion of readmissions, I think another piece we talked about is what's unique with the EHR also is the information going back to the ambulatory care provider, because if you just keep putting out the readmission rates or claims data it almost just puts the spotlight on the hospital. What did you do wrong that this person is coming back in so many days? We've got to tie in that visit that might have happened in the ambulatory side and that's what we thought was a little bit of leverage here for

But I just want also to make a comment that I fully admit when I first started participating in here and there was a call for parsimony I couldn't get my head around that at all because we're trying to involve everybody and yet we want less. And I have to say there's a glimmer of hope here to me though when you start to even look at some of these now, and I'm going back to the comments about bringing in the patient because you really can't do very many of these potential overuse of diagnostic tests or overuse of medications unless that has been part of the discussion with the patient and part of the goal setting. So I think it would be very interesting through your RFI process to encourage those who respond to make the connections and it's through that that we might actually get a little bit of parsimony, if I'm making sense.

Christine Bechtel – National Partnership for Women & Families – VP

Great point, Karen. Jim?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Just to support Daniel's point, one of the easiest things for an HIE to do is to capture admission and discharge data of EDs and hospitals and feed that into the system automatically.

Christine Bechtel – National Partnership for Women & Families – VP

Do we have any questions from folks on the phone? I don't want to forget you all. Terrific. Well, thank you very much, Bob. This is a great discussion and efficient. I love it. Our next group that we're going to hear from is Care Coordination, Tim Ferris. Is Tim on the line?

Timothy Ferris – Massachusetts General – Medical Director

Yes, I am.

Christine Bechtel – National Partnership for Women & Families – VP

Hi, Tim. Great to hear your voice. Take it away.

Timothy Ferris – Massachusetts General – Medical Director

I'm sorry I'm not there. Like others, I have to applaud my team, who worked very hard and there were even e-mails going last night, which unfortunately those thoughts didn't get included here, but just to acknowledge the enthusiasm of the team and the contributions.

I'm going to go very quickly here. We first looked at what the sub-domains of care coordination might be. This is an exercise that brings out in all of us whether or not we're lumpers or splitters, and we had both on the group, which makes for a lively discussion. We eventually prioritized for effective care planning, care transitions, appropriate and timely follow up and intervention coordination. Just what exactly goes into all of those is in the text that you can read here, and in the interest of time I'll let you do that as people want. We then looked at measure concepts that might map to those four sub-domains and we used an iterative process where we went back and forth between the existing measures in the Gretzky report and then more blue sky thinking about what we would like to see.

I'll skip the next page and go to page five, and just go through the eight, maybe nine measure concepts that we prioritized. Under effective care planning we prioritized measure the presence of a comprehensive clinical summary in the EHR with an up-to-date problem list. In the written document

there's much more detail about this, so there are some nuances and subtleties to all of these, as you would expect.

The second one, measure of receipt by patient of a self-management plan for patients with a condition where this might be reasonably considered to benefit the patient. And then the third under effective care planning, measure of advanced care plan, and this obviously goes to a special population. We had some discussion about whether or not this could be covered in one of the ones above or should be called out separately, but because of the importance of the topic we decided to call it out separately.

Moving to the next page, six, under care transitions this was an area where we actually had a lot of existing empirical measures and when we first focused on existing empirical measures we had relatively few in the other three sub-domains and many options within this domain. So this is probably an area that is ripe for measures that can be immediately applied, because there are quite a few that have already been developed. Among the measure, when we look at these, the measure concepts that seemed most compelling to us, and I have to say that we had a lot of discussion about this because there were others that were also compelling, were measures of reconciliation of all medications when receiving a patient from a different provider, so a med rec., measure of receipt of patient and care team members of a comprehensive clinical summary after any care transition.

We had a lot of discussion on our team about the HIT sensitivity of transactional communication. It is possible to measure both the content and timing of when communication occurs if it occurs electronically and the communication among care team members, which includes the patient, is highly amenable, if it's done electronically, to measurement. So I think I'm going to step outside of the specific team discussions, but I'd say this was an area where we thought there was great potential for measurement.

But the implications for the parsimony issue, which I believe Karen was just speaking to, which is there are lots of different kinds of potential electronic communications that support care coordination and coming up with parsimonious measures rather than what we had available to us, which is a measure of referrals and a measure of response to referrals and a measure of discharge summaries, there's lot of individual measures of individual communications and whether or not that could be developed as a measurement concept into something that more comprehensively looked at it. That is more of an aspirational. We didn't see that measure as existing.

The third on this page was measure of patient and family experience of care coordination across a ... transition. We had a lot of discussion about the fact that ultimately care coordination is a patient centered concept and should be measured at the patient level. We realized that this was fundamentally not on our team, this was to the patient and family centered team, but we couldn't resist the opportunity to prioritize it here and hope that our prioritization here and the overlap that the patient centered team will just further reinforce that.

Moving to the last page, page seven, concept three, appropriate and timely follow up. This is obviously a key element of care coordination. The concept we came up with was assessment of timeliness and providing an appropriate response to clinical information including lab and diagnostic results. The wording there is a little vague. I think what we meant to say was timeliness of the provider response and the appropriateness of the provider response to clinical information, including lab and diagnostic results.

Then finally, intervention coordination, and here we thought among the many we looked at that the most compelling was assessment of duplicative test orders, understanding that this overlapped with the efficiency group. I would invite any of my team members to add anything or I'll take questions.

Christine Bechtel – National Partnership for Women & Families – VP

Terrific. So the queue starts with Peter. Thank you, Tim.

Peter Basch – MedStar Health – Medical Director

This is terrific. Thank you very much. Two questions, one is the same question I asked several of the other groups, did you consider applicability across setting, inpatient, outpatient, and specialty for the sub-domains that you discussed? And the second question, did you consider as a sub-domain something which seems pretty obvious to me and actually was in testimony I presented to the HIT policy committee this summer, which was ongoing multi-provider care as a sub-domain of care coordination?

Timothy Ferris – Massachusetts General – Medical Director

The first question, right on target, how can you talk about care coordination without addressing the issue of between sites of care? That is a fundamental idea that undergirds what care coordination is. We looked at a bunch of measures that really depended on HIE or they depended on care being received within a system. We looked at a few measures that had we a robust health information exchange they would be great measures. But they seemed aspirational insofar as we didn't think we were going to be there for phase two. So I think, like I heard the other team, we struggled with the tension between aspirational measures and measures that were more proximal, but clearly transitions between site of care and the issues associated with specialties and so forth were very much on our minds. With the exception of the end of life we didn't look at specialty specific measures, although we didn't prioritize those concepts because we felt that they were not parsimonious, and so we were trying to keep that in mind. I will say that when I think about elaborating any one of these concepts into specific measures, they immediately call to mind many specialty specific opportunities.

So that was a long answer to question number one, and so of course I've lost what question number two was.

Peter Basch – MedStar Health – Medical Director

I'm not sure that in your long answer you answered both. So question number two was consideration of ongoing multi-provider care, not care transitions but ongoing care, average Medicare beneficiary has how many docs, seven, nine, it depends on what you read—

M

More than one.

Peter Basch – MedStar Health – Medical Director

More than one, because some consider the process of care coordinating as a verb rather than an event as ongoing and I think, at least based on what I've read, so far untouched by the sub-domains that you've presented.

Timothy Ferris – Massachusetts General – Medical Director

I guess I would disagree with the assessment that it's untouched. I would say that the measure concepts, we did discuss longitudinality. Obviously with care coordination there was a lot of discussion about longitudinality. I think this comes down to the lumping and splitting that I referred to at the beginning, the fact that we didn't call it out as a sub-domain. I don't see necessarily how you could measure things over time that don't involve the measurement of the specific things that we called out. So one could just take a different lens on the measure concepts and say add up these things over time and they become longitudinal. We didn't choose the domains. Another group, another person could definitely have chosen that domain and I think your point is very valid. But you can't think about care coordination without a longitudinal element.

Christine Bechtel – National Partnership for Women & Families – VP

I have Jacob and then Farzad and then Karen.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

As a family doctor I think these are great measure concepts and I would aspire to try and measure these things. As CMIO for an EHR vendor I found myself scribbling on all of the slides how are we going to measure these things. I have to translate some of these things into queries for our developers to then go and ask the database the question so that we can generate the answers for the eligible providers. So the question is, did you think about that and what thoughts did you have?

Timothy Ferris – Massachusetts General – Medical Director

Actually, we thought a lot about that. For example, just turning to the care transitions page, there are examples of those three measures that we looked at in the Gretzky report. We measure a lot of that stuff here within partners because it is fairly easy to manage when a communication occurs. Now, understanding getting the attributions right, understanding whether or not that communication was related to the denominator event of interest, those are all the bugaboos that make measurement so much fun. There are definitely issues. I would say to my very concrete mind they're less distant and aspirational than a lot of the concepts that we've been talking about today. So I think there are some concrete measurement opportunities here.

Christine Bechtel – National Partnership for Women & Families – VP

I think, to be fair, that's the scope of the RFI too. Our question today is, are these concepts the right ones and taking off the table anything that isn't so that we can put forward a set of recommendations at the end of the day around the ones that we think are the right ones. So I think it's good. Farzad?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Two comments. One is on the care transition, ... even the long term care facilities are not eligible for meaningful use, that's really a critical aspect that we need to bring in to capturing the transitions between acute care, home care, long term care, is really critical for us to capture somehow. So I urge the team to think about how we can incorporate that.

The second is getting somewhat to Peter's point, it may not be immediately obvious but one recommendation from this group around meaningful use quality measures could be around group reporting of quality measures, which would encourage team based care rather than the way it's currently defined on a per provider reporting care, which carries with it some of the contradictions of we want to encourage team based care and yet we're asking quality measures on an individual provider level.

Timothy Ferris – Massachusetts General – Medical Director

Farzad, that is a terrific comment. I have to say we didn't, to my recollection. So if I could just restate what I thought I heard you just say, any measure of quality that is attributed to multiple providers is in some ways a care coordination measure because of the very nature of your attributing it to multiple people as if they are in a group taking responsibility. I think what you've just done is given our Tiger Team possession of the product of all the other Tiger Teams.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Similar to what the population health folks did with the disparities, in a way.

Timothy Ferris – Massachusetts General – Medical Director

Yes, correct. But I think that's a terrific addition, Farzad, and something that we didn't think of.

M

If I could dispute that for a minute before we pat ourselves on the back too much. That may be true and it certainly may not be true. Sometimes you can achieve good quality metrics in spite of what the dueling care team has done, the patient has suffered through parallel play at the hands of half a dozen providers

and been totally confused by conflicting recommendations and somehow still ended up with good quality measures. If we bring in, as Eva talked about before, experience of care and maybe looked at also efficiency of care, it's possible that the group quality metric is fine, but the patient experience was terrible and the efficiency was beyond terrible.

Christine Bechtel – National Partnership for Women & Families – VP

Good comment. Karen?

Karen Kmetick, AMA

I just wanted to ask Tim, is there a sub-domain somewhere between the patient and family engagement sub-domains and these effective care planning sub-domains, something that says, simply as the goal of treatment is recorded in at EHR and it was discussed by the patient and the provider. I'm just wondering if there's something missing, because when I think about the patient engagement it's all about surveying the patient, what did they think about their experience, were they involved in making decisions, and then here it's do they have self-management. But again in the spirit of maybe is there an interim step, is there the goal, I guess I want to get to the goal of this treatment.

M

I think, Karen, ... some way to capture ... success because that's going to be different than the patient's rank and we shouldn't assume necessarily that every care coordination team is ..., so I'd echo that.

Timothy Ferris – Massachusetts General – Medical Director

I think our first measure concept under effective care planning, the details aren't here. The details are in the write-up. A comprehensive clinical summary should include goals of care. I can't imagine one would make a definition of a summary that wouldn't include goals of care, but if we missed that in our haste that was certainly part of our discussions and should absolutely be part of this.

Christine Bechtel – National Partnership for Women & Families – VP

Great, thanks. That's a good point, Karen. So between the care coordination and patient and family engagement that's definitely a pickup we need. Joachim and Dan, and then I think we've got to move on.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

One of the challenges I see in measuring interactions is measuring the mere presence of an interaction versus the quality of that interaction. I'm just sort of thinking to myself looking at these concepts too what I do with copies of contracts or warranties, I guess, from different providers, and depending on how I interact with that particular vendor or whoever I get these documents from I might have a very different takeaway. So I wonder if your team discussed this notion of how "meaningful" is it to measure if somebody was handed a document versus was there some interaction around that document.

Timothy Ferris – Massachusetts General – Medical Director

That's a great point. We actually spent quite a bit of time talking about that, and in our more detailed write up, and I hope it's reflected in the document, that we thought it would be good to measure that communication happened at all, because often it doesn't, but more aspirationally we would like to look at the content of that. I'll just one example. The discharges from Mass General to post acute care, we measure both the receipt of the actual documents by the receiving institutions and we also measure, we actually count elements that we believe are essential to that communication within that document. And of course that's a laborious measurement exercise, we're trying to make it electronic, but I think that speaks on a very basic level to what you're speaking to on a more conceptual level. It's very, very important and essential to good care coordination.

Daniel Green – CMS/HHS – Medical Director

Just very briefly I wanted to follow up with what Farzad and Peter said. I think they're both right in terms of measuring at a group level and sometimes measuring at an individual level. We faced these challenges in PQRI and we found that a lot of Medicare providers specifically don't have enough patients with one particular disease condition that we can effectively measure and say oh, you're doing a great job or you're doing a poor job. Similarly, if they are practicing in a group, did Farzad order the hemoglobin A1C or did you order it, Peter? Do we really care who ordered it as long as both of you checked it and you're working toward getting the patient under control. So these are some of the challenges that we face already in this program and I think that's why, depending on the situation, it affords itself both opportunities.

Timothy Ferris – Massachusetts General – Medical Director

I think that's a great comment. We've just implemented a measure here where we're measuring our cardiologists and our primary care doctors on the LDL control and the hypertension control of patients that they share. And it's been a very interesting exercise because after the finger pointing goes away, they actually divide and conquer and are communicating, maybe in some cases for the first time, about whose responsibility it actually is. And it's been a very productive dialogue just to put that measurement in place.

M

Tim, how long does it take for the finger pointing to go away?

Christine Bechtel – National Partnership for Women & Families – VP

We'll take that as a rhetorical question. Thank you so much, Tim. That was terrific. So now we're going to jump into the methodologic discussion that Jon and Helen are going to lead us through.

Jon White – AHRQ/HHS – Director IT

Esteemed colleagues, it's a great pleasure to be presenting to you today to such a distinguished group, doubly so to be doing so with an outstanding mentor, Helen Burstin. Triply so, because four years ago Helen and I ... opportunity that was seized by many people on this workgroup, so it's lovely to see well spent taxpayer dollars coming to fruition in this discussion.

The wonderful discussion that has preceded all of this about the what we measure tees up the conversation of how. So we are a little different than everybody else. The staff team wisely said maybe we can do a little parallel processing here of some of the how issues and as the what is teed up by the different Tiger Teams we can gather people to start raising the issues with how this gets done. So you see listed before you an outstanding group of individuals that got the opportunity to meet once, and I think the questions that were asked to be addressed were issues with longitudinal measurement, delta measurement, and automated reporting of adverse events. I think you will find that discussion not only richly satisfying but over achieving in that we hit some other topics and maybe even slipped a little into some of the things we might be able to do.

I will turn it over to the excellent Dr. Burstin.

Helen Burstin – NQF – Senior VP, Performance Measures

Thanks, everybody. We had a very short time to take on what was a scary amount of potential topics here. We did try to do a bit of focusing, we literally had one long meeting and a short interim meeting to do what seems like something that could take a very long time. We did focus, as Jon mentioned, on these three specific areas. These were, at least the first two were specifically highlighted in the ... care report that builds out of the work of the Gretzky report, the Gretzky group. Specifically, since so many of

the committees, so many of the workgroups focus on longitudinal measurement, this issue of what are the methodologic challenges of making some of those measures a reality.

The second one that came up under the population health group, for example, was how do you look at measures that look at change over time, these delta measures as we refer to them. So getting against a delta rather than just achieving a threshold. And the final one that was passed on to us primarily because of the work of the safety workgroup was thinking through how we would get an adverse event reporting ... and what would be the methodologic issues there. We did have a quick opportunity to look at the bullets of the measure concepts from the other Tiger Teams and we couldn't help ourselves and quickly looked at a few of those issues as well. So I'm going to run through each of these very briefly.

First, in terms of longitudinal measurement, it was probably the most difficult of the methodologic areas that we had to deal with, it's very clear that so much of this is dependent on interoperability. But we also talked about some other broad issues. The idea of being able to harmonize measures across data platforms brought up this issue again of can you really achieve much of this without shared patient identifiers. The issue of attribution, that we just talked about earlier, came up big time in terms of looking at actually the public reporting of these measures in attribution and how would you do that in an environment where data is more longitudinal and shared and does it matter, as was pointed out earlier. We had a long discussion that I'll come back to, it won't take very long, to talk about this issue of the heavy reliance on the problem list to get at the assessment of conditions and diagnoses particularly over time, and I'll come back to that. We have a separate slide on that.

I mentioned interoperability, and then there were also some concerns that although some of the concepts we all talked about, for example, medication reconciliation was one example that was brought up, that the longitudinal data would be very helpful, there are some concerns that sometimes that becomes a check box measure and that's not the intent, and could there be other approaches that would get at that longitudinal nature of concepts like medication reconciliation in several different ways, so for example structural approaches that might provide better information, for example, with a medication list exchanged between providers? Patient experience, can the patient actually report on this perhaps better than the way we would do it longitudinally in an EHR.

Then lastly, are there other examples where in fact, as was talked about during the efficiency workgroup, are there places where claims data actually integrated with EHRs do a better job of some of this and we shouldn't always just assume we have to rely on the EHR to capture all these data. The example we talked about was, for example, the first follow up after hospitalization, very easy to track, and claims data, somewhat more difficult to track unless you're in a fully integrated system with your EHR.

So delta measurement, we talked a lot about when these measures are most appropriate and what value do they add. There were some concerns, for example, that not all measures would work this way and we really need to consider which measures are most amenable to a change longitudinally, a delta measurement rather than only a threshold. There were many additional issues brought up about what would be the appropriate point in time to track to look at the delta. When would point zero be and when would the follow up point be to get at those changes. Some discussion about what would be the standards for the degree of change, just like we talk about many of the current measures having a threshold, there's probably still some need to come up with what the standard would be of ... change, for example, potentially if you think about public reporting of some of these.

Lots of concerns, of course, about the completeness of data when you start looking across different settings, concerns that some outcomes don't have a linear trajectory and sometimes you may be looking

for improvement when in fact for many of our patients they go up and down and up and down and how do you then really make sense of the delta.

There was also a discussion of, there's such limited experience to date with using these kinds of measures and I'd be curious to learn more about what your students ... and what they've learned, but do they add value? So we at least begin to understand when they add value above and beyond a threshold measure, for example. Also raise the issue of when there are untoward clinical effects that you can't track. If you are pushing blood pressure pretty far down if you get to an impressive delta in blood pressure you may run the risk, in fact, of leading to clinical endpoints you don't want that could actually be not helpful for patients.

How do we look at, and this came up again earlier in the population health group as well, how do you account for tests not performed. So you can build it into your measures, so for example you always immediately pull out the group who didn't have the A1C to start with, but the point was raised by ... was that at a population level it's still really important to think about the patients who never came in and deltas may not really get at that.

Then lastly, I think the strongest interest from this group was really about the delta's before and after procedures, the more health status based work around, for example, some of the preference sensitive procedures like cataract, back surgery, knee and hip, for example.

The last big methodologic issue for us was this issue of adverse event reporting and I think this was one many people in the group felt was very future oriented. It seems very difficult to do. We had a couple of examples where FDA has been doing some work to date on coding adverse event capture into EHRs. Some barriers that were raised were limitations in coding and capture, particularly of medication related adverse events, difficulties in integrating into clinical workflow, although again the two examples that the FDA person was able to share with us indicated you could actually do this quite rapidly if it's designed in the right way and built into clinical workflow. I think that was really the most important take home. Very little information that is available in most of these systems about the level of harm from the adverse events, so simply having had an adverse event without knowing its impact is probably not completely satisfying.

There was a discussion of whether there are potentially better ways to do this. Should we, for example, think about targeting the high impact medications, the high impact safety areas and really focus on those rather than developing big reporting systems that seem a bit pie in the sky, but obviously important and aspirational. Again, the issue that was already raised by the safety team of alert fatigue and how that might play into it.

Lastly, just a couple of more general methodologic issues that came up. There were some concerns raised at the beginning of our discussions about should we also think about quality measurements here in an incremental fashion, that's incremental to the complexity of what EHRs can actually handle. That a lot of this was blue sky and sounded great, but if it wasn't doable should we also stage some of that complexity going forward.

There was a lot of discussion also just recently brought up in the previous discussion about how we might utilize HIEs to capture some of this data across providers. Issues of interoperability came up routinely, especially when you look at wanting to look at important measures like duplicate lab testing, how do we do that without the systems to capture it.

Lots of interest in the equity discussion earlier and thinking there were some methodologic issues there, but ensuring we're standardizing the strata to be able to stratify those measures. Since David Baker was of course on our committee I couldn't help but of course ask him his perspectives on literacy as related to patient report outcomes, and he pointed out that there actually are some very good emerging technologies around talking touch screens that would really allow patients to engage, and we just wanted to at least put this on the table. Then inconsistencies in coding between different kinds of providers might drive this as well.

Finally, just a couple of final thoughts about problem lists and I'm done. I talk fast. The problem lists, although we all talk about it as being so much better than claims based measures and we started to look at some of these key issues, especially the longitudinality of tracking across time, a couple of really important issues came up I think about accuracy, about coding as being somewhat highly variable, depending on the type of diagnosis, very good for certain kinds of conditions and not very good for others, the fact that there are not clear standards for how you might code problem lists in terms of active and inactive status, date of onset is also a very difficult issue to track in an EHR. And that increasingly to make some of this work, the more clinicians consider the problem list as a quality measurement reporting tool, the better they'll use it and understand it and perhaps have better standards to use it. We needed more conventions that had to do with problems that had been resolved or perhaps deleted from the list, and that it would be helpful to have some rules about consistent use of problem lists versus past medical history.

There are times where things could reside on the past medical history list and perhaps not need to be on the problem list, and considering really how we do that, and finally just guidance for the proper use of the problem list for new conditions. It may be new to you in terms of the first time you've seen them, but this patient has had the condition for ten years and you want to be able to reflect that, and a lot of the current systems don't have that degree of specificity. So we're very happy to look at other issues that have clearly emerged from the other groups but with one and a half meetings that's the best we could do.

Christine Bechtel – National Partnership for Women & Families – VP

Terrific. That is an enormous amount of work. Let me just clarify for the group that this group is going to meet more times and keep working on these very thorny issues, I must say. So at this time you're not putting forward recommendations yet, you're just giving us a sense of the problems and the scope of your radar screen. So does it make sense for us to take a couple of quick questions if we've got them, but to continue a dialogue with you?

Helen Burstin – NQF – Senior VP, Performance Measures

Yes, and I think the other thing that would be helpful now that we've actually heard the final reports of the Tiger Teams, if there are other method issues that have emerged that we didn't really talk about, and I have a list of several I've already been jotting down today, but that would be helpful if we are going to continue.

Christine Bechtel – National Partnership for Women & Families – VP

Terrific. Let's start with Peter.

Peter Basch – MedStar Health – Medical Director

I'm glad you have a problem list on there. It's one of the things that we struggle with a lot operationally and definitionally as well. I would encourage you to stick with this one, because as we move towards clinical data it really is important to make sure that we define our denominators appropriately. And one point I would make to your first bullet on accuracy of coding, it's also highly variable upon the amount of diagnostic codes that are potentially pickable for a particular illness, and which specialty is picking the

code. So in fact we might think we're getting more accurate with ICD-10, and we might just find somebody throwing a dart at a bigger dart board.

Christine Bechtel – National Partnership for Women & Families – VP

Any other questions or comments? Jacob?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I think Peter and I are going to have to do a tag team from now on, because a similar comment on the problem list. I've found that diagnosis lists, past medical history, and problem lists, all are three variants of the same kind of thing, and I think the more coalescence of what these things mean, so the diagnosis list isn't necessarily the past medical history. ICD-9, ICD-10, SNOMED CT, interface terms, I think these are great topics for us to gnash on because they're elemental, right. If we solve these problems and get as much agreement as possible, then everything else can fall into place.

M

If I could add one more quick comment on that, as we about a year ago started coming up with the patient summary, long before it was required, we were going to put problems, meds, allergies, instructions, orders, every patient visit, every time and then decided that we were so much in disarray about what a problem list was, what people put on it, whether it was a memo, what to do list and so forth, that we actually took it out of our patient summary because we felt it added zero value and lots of confusion. We'd love to add it back in and would love guidance on that.

Christine Bechtel - National Partnership for Women & Families – VP

This has been a really rich discussion today, lots of back and forth, that has been really built on a tremendous amount of thought leadership by the Tiger Teams and the ONC staff and the Quality Measures Workgroup members. So I want to first say thank you very much for this terrific amount of work that's come forward.

What I think we should do is to spend the next 10 to 15 minutes figuring out what our next steps are. And what I would like to propose is that, first of all, reflect back that as we have gone through the recommendations from the Tiger Teams, again, the methodologic Tiger Teams not being as involved yet, but will be, so we'll hear more from them.

Leaving the methodologic issues aside, I think we've heard a tremendous amount from the Tiger Teams in terms of their recommended measure concepts. As we've gone through the discussion, most of what I've heard has been additions or refinements but no large scale deletions or problems with the concepts that have been raised. So the first thing I want to do is put that out there as a statement and give you a few minutes to think about that and raise anything at this point that you want to take off the table as a measure concept, and if not, to go ahead and move that set of recommendations, largely forward, with some edits.

Those edits will be coming from a couple of things. One is I've got a list of the bigger items that I heard, and I'll rattle that off here as a summary in a moment. And then we'll work with ONC staff to capture that. Then I would invite the workgroup to raise your own things that you don't hear coming from my summary that you'd like to also ask the ONC staff to work on, so that when we circulate the concrete recommendations based on our discussion today, all of that input is reflected. So does that sound like a good process or does anybody want to suggest an amendment to that process? Jon, do you have a question?

Jon White – AHRQ/HHS – Director IT

I have a comment on your “take things off the table.” What I heard, and people can say if they think this is true or not, was much less hey, that’s the wrong kind of thing to be thinking about, which is to the credit of all the workgroups, and I heard much more 80% of that we’re not going to be able to do by 2013, so much of it being either aspirational or dependent on iterative steps that are going to be taken but have yet to be taken. So I think that there are things that people want off the table, great, ... I think now the bulk of your effort will be to say so what if this is real and what of this can we actually move forward.

Christine Bechtel – National Partnership for Women & Families – VP

I think, correct me if I’m wrong, Jon, that that is a big part of what the RFI will ask as well. So we don’t have to ... today, but that is right. There are a couple of overarching issues, I can think of three off the top of my head, and timing is certainly one of them. The ... issues are subsequent to that as well and then the other that I would add is, and I like the way that Karen phrased it, which is how the things connect together, and I think that’s how we get to parsimony, is how do we get, as David Lansky has described, to a really elegant set of concepts that you know in order to do one thing you need to do another so do you really have to measure both and how do these concepts interact.

And that’s the work that I think we still have to do. Let me go to Jim and Ahmed and then I’ll rattle off probably my summary list so that we can just have a free flowing discussion and people can add in other concepts if they’d like. Go ahead, Ahmed, either one of you.

Ahmed Calvo – HRSA – Senior Medical Officer

Just briefly, I think even though we don’t have to address some of the how-tos and the details, I’m encouraged by the convergence of the discussions from the different Tiger Teams, and I don’t think that we’re all as aware of some of the other resources that are available. To give you a concrete example, if we talk about hemoglobin A1C and the diabetes, the whole notion of something like the chronic care model, the diabetes collaborative and all that detailed stuff as to how do something at all the different levels, people seem to immediately resonate with that, but that’s because there’s a long history of that.

When you talk about patient safety and adverse drug events and preventable adverse drug events, etc., people aren’t necessarily as aware of similar work, for example, the patient safety and clinical pharmacy services collaborative that exists that HRSA has been doing ... FDA, etc., for which a lot of this detailed, validated instruments and measures, etc., already do exist. So I guess my concrete comment is we don’t necessarily have to be over worried about whether those evidence based pieces exist, because they do. It’s just that they haven’t been connected up together, which is part of what I hope we actually do in fact get to in our further discussions, depending on what ends up being the final combination.

Christine Bechtel – National Partnership for Women & Families – VP

Great point. Thank you. Jim?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

As we move forward and think about feasibility, it seems to me we need very early agreement on precisely what is the context of feasibility. It clearly isn’t an IDN with an HIE and a Beacon grant. It probably isn’t a two person physician clinic with no IT support, but if we don’t get that clear then it won’t be clear to us or anybody else who the market is, and my guess is that we need to at least make an attempt to be smart about 2013 and 2015. My guess is the context in all of our minds is a little different between those two.

Christine Bechtel – National Partnership for Women & Families – VP

That’s a great point. I’ve got it down here. Okay, so let me run through, in terms of that Tiger Team – yes, I’m sorry, Peter. Go ahead.

Peter Basch – MedStar Health – Medical Director

One other general comment I'd make is we need to remember I think that this was early on in our first meeting, the as-is assessment and where we're going on. As-is is not just where it is in this room, but where it is in the field. I'm very encouraged by the direction which we're going in and we didn't end up with like 300,000 measures today, but it looks like we really will follow the principle that less is more. That for a lot of people seeing the output of stage two measures, a lot of those people actually haven't gotten on the bus yet so how these are framed, what they look like, their reasonableness, their yes, I can do that, is I think going to be critical for perhaps more the provider community than we expected.

Christine Bechtel – National Partnership for Women & Families – VP

So as I heard the panels this morning, I think we heard some themes around the need to look more holistically at the way we measure. So we heard about episodes of care, we heard about composite kinds of measures and indices, and yet at the same time to do that in a way that is parsimonious, integrates in a broader measure context, outside just a medical context, so community resources and supports, for example. And we probably, I'll editorialize and say need to think about patients with multiple chronic conditions, which is actually a thing I can follow up with Paul Wallace off line. But Paul talked in his testimony as well about the challenge of single disease state focused quality measures when they apply to patients who have multiple comorbidities, for example.

Then we talked a lot about outcomes measures and the need to balance processes and process measures that are in fact tightly correlated to big drivers of outcomes and not to be thinking either/or but really looking at both. Then Jim, I think, posed a really good question, which is what is a real outcome that we're looking for? Is it really an intermediate process measure, blood pressure under control, or is it I'm actually doing better with my activities of daily living? The things that I heard in terms of broad theme reactions to each individual Tiger Team are as follows. Under patient and family engagement we talked about patient experience surveys and caps and some of the challenges that the RFI probably needs to look at around the identity of patients and how that data is used for their willingness to share candid information back with the provider, the sample methodology versus a census methodology, the link to information, the technology of course as well.

Then there are two other things that surface later in the discussion that I would add to this area of patient and family engagement. One is advanced directives as a measure of shared decision making. The other is making sure we're establishing patient goals and looking at whether they're met or not and that came up under the context of care coordination as well.

Under population health we talked about whether we want to suggest stratifying all quality measures by disparity variables, race, ethnicity, language, and gender. Or, this composite measure that the Tiger Team came up with, which is sort of a roll up of everything, and Karen raised the issue of what's the connection between the two that might provide a pathway for people to begin eliminating disparities?

On patient safety we talked primarily about the patient's role or the family's role in safety and wondered whether there should be an added measure concept in there. I think that's something we should go back to the Tiger Team with. And folks raised, as an example, a patient reported adverse event concept, and Paul Tang said maybe we could have a submit button through the personal health records. We also talked about the link to patient preferences back in the patient and family engagement domain. In the efficiency domain what I heard was looking at the consumer role in measurement context and again linking potentially back to the patient and family engagement measures, but conceptually in the measure concepts themselves we would still like to see some reflection of the consumer role in efficiency.

On share coordination, I heard a couple of things. This is the last area and then let's open it up for folks to add to this or revise it, or raise other issues. In care coordination I heard the need to bring long term care facilities somehow into the measurement spectrum. I also heard the discussion of group reporting of quality measures, that there is benefit to really driving team based care and the notion of a measure that is attributable to multiple providers. But then Peter did caution us to say we probably need to incorporate patient experience and efficiency in at the same time so that we control for some of the variables that can happen in team based care. Then finally, I heard, again what I had mentioned before about establishing patient goals.

So those are some of the concepts and refinements that I heard the group want to add into or revise what the Tiger Team recommendations were. So let me ask, did I get that right? What else have we missed? Is there anything that you want to take off the table? And we'll spend about the next six minutes doing that because we do need to have the chance for public comment. So I've got Karen in the queue and then Jim.

Karen Kmetik, AMA

... keeping on the table in some way Farzad's comment that then Peter and Dan both reacted to about do we want to, as a group, make any comment about some of these really need to be group based measures. Is there value in not losing that?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I have that.

Karen Kmetik, AMA

I'm sorry.

Christine Bechtel – National Partnership for Women & Families – VP

No, that's okay.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I totally agree with adding long term care. I'd add the whole rest of the health care team that we often leave out, the term of AHRQ for them is apparently long term post acute care and we capture things like rehab and things that aren't necessarily long term, but are critically important to patient and home health, that whole set of groups.

Christine Bechtel – National Partnership for Women & Families – VP

Great. I actually am going to go to the phones. I want to make sure that we're not missing folks on the phone as well. Let me ask if there are folks on the phone and then I've got Peter and Jacob in the queue. Folks on the phone, any comments? They're all eating lunch. Okay, so Peter. Jacob was first, okay.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

And Peter's more loquacious so thank you, Peter. I'll be short. Jon White did not pay me to say this, on our very first call I asked Farzad if it was in scope to talk about clinical decision support, and Jon knows what I'm going to say, and he said yes. So we heard from Fred that he thought that consideration of CDS aligned potentially with the quality measures was important and was an essential part of his success. So I would just raise that as something that I don't want to lose track of. As we think about the RFI, perhaps that could be part of the guidance.

Christine Bechtel – National Partnership for Women & Families – VP

This could potentially be something that I think is, if I'm understanding you correctly, clinical decision support of the functional capability of an electronic health record is out of scope for us, but very in scope for the meaningful use workgroup that is looking at functional objectives, whereas we're looking at quality measure objectives.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

Right, but as we look at the so-called EHR readiness component assessment of quality measures, is there opportunity in the EHR to leverage this quality measure and drive clinical decision support. So the CDS is before it happened and the measure is after it happened and it's about making it actionable. I heard Fred say that, and by the way, I didn't pay him to say it either, nor did Jon. So I think that's the concept. I'm not saying that this is completely in scope but related and should inform the quality measure work.

Christine Bechtel – National Partnership for Women & Families – VP

Absolutely. Got you, okay.

M

To the extent we're going to pay attention to CDS we need to remember that patients and home health and lots of other people make clinical decisions.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I think they're part of the CDS picture.

Christine Bechtel – National Partnership for Women & Families – VP

Peter?

Peter Basch – MedStar Health – Medical Director

Just one comment and one appeal. One comment as we do this, I'm delighted with the frugality of measures. I've been keeping a tally of how many, although I asked a question and didn't really get the answer, were more applicable to primary care specialists and I think we need to be aware of it afterwards. So that was certainly a comment that came out after the NPRM. Not that I don't think it's necessarily a good idea to do, but in terms of how we message this and whether this is going to look at something that's going to further kill primary care or attract people to the field.

The second thing is that my appeal is I actually want to make the appeal on the care coordination side that at least in my view care coordination is not an event of throwing paper airplanes at each other and saying yes, I got one. I caught one. I threw one. It's actually taking the information and synthesizing it, analyzing it, reinterpreting it in light of patient preference and acting on it. That while we could say that's kind of out of scope, sometimes how we define quality measures helps to inform how others define reimbursement. We're all care coordinating here and maybe we are, maybe we're not, so we just need to be thoughtful about that.

Christine Bechtel – National Partnership for Women & Families – VP

Other comments and questions before we go to public comments?

Paul Wallace – Kaiser Permanente – Medical Director

I just wanted to bring back and talk a little bit about the complexity piece about really two dimensions. Real patients come with multiple conditions and real patients come with multiple providers, where most of our patient ... actually assumes that patients have single conditions seeing a single provider. It almost falls out into a 2x2 table, if you think about either having a single or multiple condition, ... having a single

or multiple provider. We really have to think about how we sell all of those ... with appropriate measures. So a lot of the ... measures really are much more oriented towards the single condition, single provider, but enhanced performance often comes on a ... measure when you can engage multiple providers in addressing a single condition. Tied to that is people who may have a complex condition with multiple providers, the care may be approved by being able to attribute to the multiple group. And then the hard to sell is actually where you have multiple conditions with multiple providers. But I think the overall portfolio approach should address all of those sells.

Christine Bechtel – National Partnership for Women & Families – VP

An excellent comment, Paul. Thank you very much. Let me ask if there's anyone else on the phone who wants to make a comment about the discussion here?

David Lansky – Pacific Business Group on Health – President & CEO

I just wanted to particularly thank you for leading this discussion today. It's really been great. I've learned so much. Again, thanks to all the Tiger Teams and all the contributors from the staff who brought us to this point really quickly. We've made an amazing amount of thought progress in a short time. I really appreciate everybody's work.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I second that. It's been terrific. Jon, did you have one last thing?

Jon White – AHRQ/HHS – Director IT

...

Christine Bechtel – National Partnership for Women & Families – VP

So on that note thanks again for everybody's terrific work and a really, really robust discussion today. Let's go ahead and open it up for public comments.

Judy Sparrow, ONC

We'd like to invite comments from the public now. If there's anybody in the room who would like to make a comment please come to the microphone at the table. If you're on a telephone line just push *1 to speak. If you're on a computer you will need to dial 1-877-705-2976. And while you're doing that we'll ask Carol Bickford to make her comments.

Carol Bickford – American Nurses Association

Carol Bickford, American Nurses Association. Thank you for the extensive work from this whole composite of professionals. I have three things I'd like to address. One, I appreciate the inclusion of the plan of care as being an important component. We've often forgotten that in many of the discussions that we've been looking at and moving forward on a health care reform initiatives, the way we do business right now. Please consider that the language as you introduce that material addresses it as being inter-professional and composition and also includes the patient and family and significant others as stakeholders in this conversation.

One thing you'll also need to assure is addressed is how do we reconcile and bring into synchrony the multiple versions that will have the opportunity to create. Then you probably want it integrated into all of the domains, at least as a thought process, to confirm that it is sort of a driver of coordinating components in the discussion.

The second item I wanted to address is the fact that we need to assure inclusion of complementary and integrative medicine concepts and uses and clinicians. Many of us are those types of health care consumers and that content is lost to our information system solutions, one from the coding architecture

but two actual from integration of that as information we might be providing if it's not invited to be considered as part of our drug interactions and so on.

The third thing is in relation to the inclusion of a pressure ulcer measure that we had brought forward for consideration in the patient safety domain. We see it as being more than just a fact that you have a pressure ulcer and identify that as another event which has implications for the reimbursement piece, but that we should be looking at it from the standpoint of prevention and risk assessment to the full spectrum of care from the NICUs all the way to the long term care facilities and to ... palliative care settings as well as home health, and also inclusion of that concept through all the domains. It's not just patient safety. It involves coordination of care, family patient engagement and the other spaces as well. I want to assure that the American Nurses Association and the nursing community stand by to participate in any initiatives to move this forward.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Carol. We have no more public comments. Christine?

Christine Bechtel – National Partnership for Women & Families – VP

No more public comments. Okay, great. Thank you very much. Thanks again for a robust discussion and we will be working with ONC staff and we will circulate a product that reflects our discussion today and ask you to weigh in on that. We look forward to continuing our productive collaboration. Thank you.